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ABSTRACT

This monograph is the fourth in a series summarizing the work progress of the Human Services Manpower Career Center, a special research and development project funded by the U. S. Department of Labor. This report presents a developmental model and guidelines for organizing a working coalition of concerned community groups, for identifying major tasks, and proceeding to problem-solving joint actions. Suggestions for the composition, objectives, and organizational structure of a forces can begin to attack the major problems involved in allied health manpower planning and development. A set of proposed Illinois guidelines for physicians' assistant programs and a description of 25 barriers that restrict effective recruitment, training, and utilization of allied health manpower are appended. Other monographs are available as VT 016 356-016 359 in this issue. (SB)

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NUMBER FOUR
IN A SERIES OF FIVE
MONOGRAPHS SUBMITTED
AS A WORK PROGRESS
REPORT TO THE MANPOWER
ADMINISTRATION OF
THE UNITED STATES
DEPARTMENT OF LABOR

4

community organization for allied health manpower

VT016354

BY THE
HUMAN SERVICES
MANPOWER CAREER CENTER
ILLINOIS BUREAU OF
EMPLOYMENT SECURITY

ED 066568

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MANPOWER FOR THE HUMAN SERVICES

A work Progress Report submitted in a series of five monographs to the Manpower Administration of the United States Department of Labor under Contract No. 82-15-70-22

MONOGRAPH NUMBER FOUR

COMMUNITY ORGANIZATION FOR ALLIED HEALTH MANPOWER

ILLINOIS BUREAU OF EMPLOYMENT SECURITY
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HUMAN SERVICES MANPOWER CAREER CENTER
Myrna Bordelon Kassel, Ph.D., Director

JUNE 1971

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Chicago, Illinois 60606

This report on a special manpower project was prepared by the Human Services Manpower Career Center under a contract with the Manpower Administration, U. S. Department of Labor, under the authority of the Manpower Development and Training Act. Organizations undertaking such projects under the Government sponsorship are encouraged to express their own judgment freely. Therefore, points of view or opinions stated in this document do not necessarily represent the official position or policy of the U. S. Department of Labor.

The monograph series was prepared by Myrna Bordelon Kassel, Ph.D., Director, Human Services Manpower Career Center.

Information on how to obtain additional copies of this report and of others in this series may be obtained from the Office of Research and Development of the U. S. Manpower Administration, Washington, D. C. 20210.

This document is Number Four in a series of five monographs which summarize the work in progress of the Human Services Manpower Career Center. The Center was established in July, 1969 by the Illinois Employment Security Administrator with the assistance of a United States Department of Labor, Manpower Administration, Office of Research and Development, planning grant. In 1970, Contract No. 82-15-70-22 was awarded to the Illinois Bureau of Employment Security by the same agency to enable the work of the Center to continue for a second year.

The monograph series includes the following five parts:

I. AN OVERVIEW OF THE WORK PROGRESS REPORT

II. CAREER SYSTEMS IN STATE HUMAN SERVICES AGENCIES

III. A CORE CURRICULUM FOR ENTRY AND MIDDLE LEVEL WORKERS IN HUMAN SERVICES AGENCIES

IV. COMMUNITY ORGANIZATION FOR ALLIED HEALTH MANPOWER

V. NEIGHBORHOOD-BASED CHILD CARE SERVICES FOR THE INNER CITY

COMMUNITY ORGANIZATION FOR ALLIED
HEALTH MANPOWER

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SUPPLEMENTARY SELECTED REFERENCES

A. Community Organization for Health Manpower
B. Manpower Planning

We will describe in this monograph how one community has invented its own machinery to improve the recruitment, training and utilization of allied health manpower in a metropolitan area. There is nothing unique about the Chicago experience that cannot be replicated elsewhere if the key concerned groups decide to work together.

I

STEPS LEADING TO THE ESTABLISHMENT OF THE INTERIM ORGANIZATION FOR CHICAGO AREA ALLIED HEALTH MANPOWER

The initiative to organize this coalition of agencies was provided by the Illinois Employment Security Administrator in response to the national CAMPS* Inter-Agency Cooperative Issuance No. 70-4** which called for the development of close working relationships between local CAMPS agencies and local Comprehensive Health Planning agencies. The federal bulletin pointed out the necessity for linking manpower planning to health care planning, although specific suggestions for developing these linkages were not spelled out.

During the summer of 1970, when alternative ways for responding to these federal guidelines were being explored by the Center, the local CAMPS organization was in a state of transition and the Comprehensive Health Planning agency had not yet developed an allied health manpower strategy. Since neither of these organizations appeared to have the capability to respond effectively to the need, they joined together, along with the Employment Service and the Center, to sponsor a collaborative community venture.

These co-sponsors met with forty persons from twenty-four agencies to consider whether a mutual interest exists that might support and sustain a collaborative partnership for planning and action. Two consultants from the Institute for Public Administration in New York and the Social Development Corporation, in Washington, D. C. contributed to the discussion.

The participants expressed strong support for a continuing organization. Seventeen persons volunteered to contribute their services to prepare a statement of goals, tasks, organizational structure and membership requirements.

The first official meeting of the Interim Organization took place in November, 1970 when a statement of purposes was adopted and five task forces established to deal with specific problem areas. A Coordinating Council was set up to handle administrative matters and the Center Director agreed to serve as temporary chairman. During this first year

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*Cooperative Area Manpower Planning System, a consortium of Federal Agencies, replicated on State and local levels, to set priorities and coordinate funding of manpower programs.

**Dated December 23, 1969.

of operation, the major responsibility for carrying forward the work of the organization has been shared by Center staff, task force coordinators and members.

The organization, now comprising thirty-nine member agencies, regards itself as an interim group which will operate to meet present and projected needs. While functioning automonously at this time, it is engaged in discussions with both the Comprehensive Health Planning Agency and the CAMPS organization to determine whether either or both of these agencies have the capability and the interest to assume permanent responsibility for such inter-agency machinery or whether this interim organization shall continue on an on-going basis.

II

GUIDELINES FOR ALLIED HEALTH MANPOWER PLANNING AND DEVELOPMENT

The experiences of the Chicago organization so far indicate that the following elements are critically important in developing an effective community-based vehicle for allied health manpower planning and development.

A. STATEMENT OF PURPOSE

All participating agencies need to agree on the problems to which the organization is addressed and the purposes of the organization. For example the Chicago organization has stated,*

"The purpose of this organization is to provide a vehicle through which all concerned organizations can work together to promote the recruitment, training and optimum utilization of allied health manpower.

This partnership is being formed because no machinery presently exists for communication and linkage among the various organizations engaged in recruitment, planning, training, funding and placement functions in the allied health manpower field.

This inter-agency coalition provides a potential local vehicle for implementing the intent of the inter-agency Cooperative Issuance No. 70-4 dated December 23, 1969, in which nine federal agencies comprising the Cooperative Area Manpower Planning System (CAMPS), called for the establishment of close working relationships between local CAMPS agencies and the Comprehensive Health Planning Agency.

We are also aware that certain needs, problems and barriers presently exist which we are unable to deal with effectively as individual agencies. We believe, however, that in an organization of this kind, channels can

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*The following quotations are abstracted from the Statement of Purpose of the Chicago Interim Organization.

be created for maintaining inter-agency communication, providing mutual assistance and support, developing and testing new models, bringing about a more rational division of labor among the member organizations and taking joint action to remove unjust restrictions."

B. SPECIFIC OBJECTIVES

From these general purposes, specific objectives need to be spelled out, such as:

1. To identify allied health manpower needs and recommend priorities for the development and funding of manpower programs.

2. To communicate these needs and priorities to the appropriate authorities responsible for implementing health care services and manpower development programs.

3. To assist employing agencies to re-evaluate their staffing plans to make optimum use of scarce professional personnel.

4. To examine present job structures with a view to opening opportunities for new manpower to be brought into the health occupations and to improve the salaries and working conditions for allied health workers.

5. To design career ladders which will give every worker an opportunity for upward mobility and which will reduce the wasteful turnover of manpower.

6. To help to design core curricula which give workers a wide choice of possible occupational pathways in the health field.

7. To recommend steps toward the removal of restrictive legal and licensing barriers that prevent effective recruitment and utilization of needed manpower.

8. To provide a vehicle for the examination of developmental proposals for allied health manpower and to use the expertise of this organization for consultation, review, and recommendations in keeping with agreed upon priorities, quality standards and optimum utilization of all available resources of the community.

9. To support the expansion of the training capability of the community in order that needed health workers may be recruited and prepared for work in this field.

C. MEMBERSHIP

In an organization of this kind, membership should be comprised of the representatives of metropolitan or city-wide organizations, as well

as any sub-regional health planning organizations being developed in a community under the Federal Partnership for Health Act of 1967. The sub-regional health planning groups are particularly essential in that they are expected to reflect a broad base of consumer participation in the planning process.

An organization already represented through a city-wide or sub-regional group may be accepted as a member of this organization with the approval of the city-wide or sub-regional organization to which it is affiliated.

Membership participation should be invited from, but not restricted to the following major groups of agencies concerned with allied health manpower development:*

(1) Health Planning Agencies

(2) Consumer Organizations Representing Diverse Economic and Ethnic Groups

(3) Employer Groups

(4) Agencies Providing Recruitment, Training and Placement Services

(5) Agencies Planning and Coordinating the Funding of Manpower Development Programs

(6) Educational and Training Institutions

(7) Professional Organizations, Associations, and Unions

Each member agency should be represented by one individual designaated by the administrative head or that agency. In order to maintain continuity of participation each agency can be asked to name a second representative who will participate in the meetings of the organization when the first named representative cannot be present.

D. CONSULTANT PARTICIPATION

Participation should also be invited from interested individuals and organizations who are able to provide consultation and other assistance to the organization in special problem areas.

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*See following page for list of agencies presently participating in the Chicago Interim Organization.

The Interim Organization for Chicago Area Allied Health Manpower

201 NORTH WELLS STREET CHICAGO, ILLINOIS 60606

MEMBERS AND CONSULTANTS

Chicago Board of Education
--Bureau of Health Occupations
--Health Occupations Careers

Chicago Board of Health

Chicago Committee on Urban Opportunity

Chicago-Cook County Council #19
American Federation of State, County and Municipal Employees, AFL-CIO

Chicago Dental Society

Chicago Medical School

Chicago Hospital Training Directors Assn.

City Colleges of Chicago

Comprehensive Research & Development (COMPRAND)

Cook County Dept. of Public Health

Council for Bio-Medical Careers

Developmental Program for Comprehensive Health Planning

Health and Hospital Governing Commission of Cook County
--Department of Education

Health Careers Council of Illinois

Illinois Bureau of Employment Security
--Human Services Manpower Career Center
--Illinois State Employment Service

Illinois Nurses Assn.-Chicago District

Institute of Medicine of Chicago

Mid-Southside Health Planning Org.

Moraine Valley Community College

[illegible] Careers Council of Metropolitan Chicago, Inc.

No. Suburban Assn. for Health Resources

Office of the Mayor
--Model Cities Program
--Special Assistant for Manpower

Prairie State College

Rehabilitation Institute of Chicago

Southern Christian Leadership Conference
--Operation Breadbasket

The Woodlawn Organization

Thornton Community College

Triton College

Welfare Council of Metropolitan Chicago

Westside Health Planning Org.

YMCA Community College

STAFF OF THE FOLLOWING SERVE AS CONSULTANTS:

American Hospital Association

Illinois Regional Medical Program

Presbyterian-St. Luke's Hospital

University of Chicago
--Hospitals & Clinics
--Pritzker School of Medicine

University of Illinois
--Medical Center
--School of Associated Sciences

A consortium of health, manpower and educational agencies and community organizations working together to support and strengthen the recruitment, education and effective utilization of allied health manpower in the Chicago Metropolitan area

E. EXTENT OF AGENCY COMMITMENT

No individual agency which is a member of such an organization is expected to participate in any function or support any action of the group without the prior approval and consent of its designated representative. In all cases, common consent should be the condition for any organization's participation in a particular course of action decided upon by a majority of the members.

F. PROBLEM-SOLVING TASK FORCES

In order to provide the machinery for inter-agency planning, communication and problem-solving, task forces should be established as needed. Recommendations emerging from these task forces should be presented to the general membership for approval before any joint inter-agency action is undertaken by the organization. Such task forces might address themselves to the following areas:

1. Technical Assistance

The purposes of this group can be to review and evaluate proposals for the training of allied health manpower, to offer consultation to agencies requiring program assistance, to act as a broker between agencies seeking resources for implementing their programs and the available resources.

2. Manpower Priorities

To develop a process by which health manpower needs in the community can be identified, including present budgeted as well as projected vacancies; to establish a priority system based on existing needs which can then be communicated to manpower funding agencies and health planning agencies.

3. Barrier Removal

To identify restrictive legal, educational and administrative barriers that inhibit the effective recruitment, training and utilization of allied health manpower; to develop strategies and propose joint actions calculated to remove these barriers.

4. Education Resources

To provide an opportunity for the high schools, colleges and other training institutions to work together on common problems, such as (a) development of a health core curriculum, (b) articulation of credits between institutions, (c) training of health education instructors, (d) development of proficiency testing and (e) increasing the training capability of the community.

5. Occupational Development

To encourage employers of allied health manpower, unions and professional organizations to undertake career development programs; to provide a means through which such programs can be linked to available funding and training resources; to work towards the standardization of job specifications and salary ranges.

III

EXAMPLES OF THE PRODUCTS OF THE TASK FORCES

In order to illustrate how an inter-agency coalition of this kind can contribute to problem-solving in matters relating to allied health manpower, we will describe the projects of four of the Chicago task forces: technical assistance, barrier removal, occupational development and manpower priorities.

A. GUIDELINES FOR PHYSICIAN'S ASSISTANT PROGRAMS

The Technical Assistance Task Force addressed itself to the development of guidelines for Physician's Assistant programs within the State. In collaboration with a State Inter-Agency Task Force on Health Manpower, an Ad Hoc Committee was formed comprised of approximately twenty-five individuals who met over a period of three months to hammer out a consensus on the major issues. The twenty-five individuals who participated in the dialogue which produced this document represented a variety of interests and concerns with respect to the training and utilization of Physician's Assistants. Among the participants were persons affiliated with:

(1) Health Service Institutions who see in this new health worker a means of relieving present staff shortages;

(2) Education Institutions who are committed to developing viable training programs to meet community health care needs;

(3) Manpower Authorities who see in this emerging occupation an opportunity to provide jobs with genuine career opportunities for new health care workers; and

(4) Professional Groups who are concerned with the ways in which the Physician's Assistant would affect the roles and responsibilities of other health workers.

Common to all of those engaged in this effort, however, was a concern with the total health manpower crisis and a commitment to explore ways in which the development of Physician's Assistant Programs might serve

the needs of the people of Illinois within the framework of the existing and emerging health care delivery system. It was this common concern which made it possible for this diverse group to identify key issues and move toward some working consensus.

The process involved in building a consensus around the complex and controversial issues concerned with this subject began with the group's effort to identify the major questions which they had to confront. Once this was accomplished, the procedure was to encourage full discussion and debate on each issue. Each meeting was followed by a written summary of the areas of agreement and disagreement. Over a period of three months the group continued to return to the still unresolved issues, to redefine and restate its positions. At the final meeting closure was achieved with the understanding that additional feedback on the document would be solicited from the two co-sponsoring organizations and that contributions including dissenting opinions would be incorporated into an appendix.

The guidelines document was completed in May, 1971 and submitted to both organizations who had assembled the Ad Hoc Committee for their review and further action. It was subsequently approved by both groups, as well as the Illinois Regional Medical Program and is being prepared for widespread distribution.

This document represents only a beginning. Many of the remaining issues and unresolved problems will be dealt with only as actual training programs emerge and Physician's Assistants begin to be utilized in the health care system.

Because of the widespread interest in this subject throughout the country, we have placed these guidelines in Appendix II. We offer them as an illustration of consensus-building around the basic issues involved in allied health manpower planning within the framework of career development concepts. We suggest that guidelines such as these are relevant to other states and cities who are planning to train and use Physician's Assistants.

B. IDENTIFYING THE BARRIERS

From its inception the Interim Organization for Chicago Area Allied Health Manpower recognized that certain education, administrative, economic and legal barriers exist which seriously inhibit the City and the State from dealing effectively with the allied health manpower crisis. The Barrier Removal Task Force, therefore, proceeded to identify these barriers and their consequences as a first step toward the removal of these barriers.

Contributions to this study came from the following sources: (1) Sixteen persons selected by the task force on the basis of their comprehensive knowledge, experience and leadership in the health manpower field.

Nine of these persons were personally interviewed; seven submitted written documents containing their views and recommendations. The names of these individuals are listed in Appendix III. (2) A study of the extensive literature dealing with this subject matter, selected references from which are contained in our bibliography.

During the five-month period in which this study was being completed, a consortium of State agencies and voluntary organizations concerned with health manpower came together to form the Illinois Inter-Agency Task Force on Health Manpower. This group, of which the Chicago Interim Organization is a member, undertook to identify its tasks and priorities. The product of this effort was a comprehensive inventory of the specific actions to be taken to solve the critical problems facing the State in the recruitment, training and utilization of health manpower. In completing this document, the Center staff drew upon the work of the Illinois Inter-Agency Task Force which was still in process. In virtually each case, they were able to match the various barriers identified in this study with the tasks set forth by the Illinois Inter-Agency Task Force. Both pieces of work, it turned out, were highly congruent and reinforced one another.

On April 1, 1971, Governor Richard B. Ogilvie, in his health message to the General Assembly, called for:

". . . a moratorium on creating additional licensing and certification categories for health professions this year. . . I urge this Legislature to establish a commission with adequate appropriations to perform the evaluation and planning that is needed. This will include review of the existing laws, regulations and administrative procedures for licensure and certification. It will examine and recommend the relaxation of administrative regulations to remove existing barriers to competent individuals. . ."

A few weeks later, the Illinois Inter-Agency Task Force on Health Manpower accepted the invitation of the Governor's Office of Comprehensive State Health Planning to collaborate in identifying specific ways in which the recruitment, training and effective utilization of health manpower could be strengthened now within present statutory requirements.

In view of these recent developments and the continuing urgency of the health manpower crisis, we believe this is a timely document and one which can contribute to the removal of these restrictive barriers.

The developments in Illinois are not unique, nor are the twenty-five barriers identified by the study. The problems are clearly nationwide in scope and, except for a few states such as New York, which operates a highly successful Proficiency Examination Program, are still unresolved.

The barrier list includes the following areas of concern:

Data for Planning
Today's Vacancies
Machinery for Health Manpower Planning
A Manpower Plan to Accompany all Program Proposals
Training Availability
Location of Training and Testing Sites
Potential Trainees
People Excluded
Training Design
Over-training and Under-utilization
Obsolete Training Techniques
Competence Testing
Teacher Shortages
Continuing Education
Attitudes of Administrators
Vocational Education Unnecessarily Delayed
Personnel Structures and Standards
Vertical Mobility
Horizontal Mobility
High Turnover and Attrition Rates
Health Team
Program Funding
Professional Versus Public Interest
Limitations on the Number and Kinds of Training Programs
State Licensure and Certification

The task force which undertook this effort is presently mapping its strategy for distribution of this document and is setting up priorities for action to implement its recommendations.

In Appendix II these barriers are set forth, along with a description of their consequences, recommendations for change and a progress report on constructive changes now taking place in Illinois.

C. DEVELOPING EMPLOYER COMMITMENT TO CAREER PROGRAMS

The Occupational Development Task Force selected as its first endeavor the planning of a Career Development Conference directed toward the employers of allied health manpower. The newly formed Chicago Hospital Training Directors Association and the Interim Organization co-sponsored this event. The meeting took place on May 14, bringing together ninety-five persons from fifty-one organizations. Each hospital was invited to send a team, consisting of its administrator, personnel director, training director and nurse educator.

The meeting was designed to stimulate the planning and implementation of upward mobility programs for allied health workers who, for the most part, are locked into dead-end jobs. The Mayor's Office of

Manpower and the American Hospital Association were both invited to present statements indicating their keen interest in and support of this effort. A team including representatives from the University of Chicago Hospitals and Clinics, the Employment Service and the Community Colleges presented a panel showing how one comprehensive program actually works to provide basic education, G.E.D. preparation and accredited training for upward mobility on a release time basis.*

The Conference was seen as the beginning of a concentrated effort to bring employers together with the funding resources available through the Employment Service and the training resources available through the community college system. The Employment Service assigned two persons to assist the hospitals in developing proposals and the Interim Organization committed itself to functioning as a clearinghouse and broker between the employers and these resources.

This is an example of the kind of partnership effort being developed through the Interim Organization, one that can be replicated in other communities committed to career development in the allied health occupations.

D. LOCAL PLANNING FOR ALLIED HEALTH MANPOWER

The Manpower Priorities Task Force has had the primary responsibility for designing a planning system in the Chicago area for allied health manpower programs. The Mayor's Office for Manpower has consistently stressed the need for developing and sustaining a planning cycle which will identify needs, establish priorities for funding and implement program models which can provide high quality training, effective job placement and opportunities for career mobility.

The Interim Organization responded by instructing this task force to review and assess alternate planning models, particularly those which might provide local planning bodies with specific techniques for identifying health manpower needs. This was a particularly frustrating endeavor. While both national and Chicago area labor market research authorities were acutely aware of the need for local data, such information was unavailable and no program for acquiring it was being considered in the early months of 1971.

1. The Feasibility Study of a Job Vacancy Reporting System**

In the effort to find a practical handle for identifying manpower needs, the Center undertook a brief investigation of the

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*See following page for University of Chicago Hospitals and Clinics clerical, laboratory and nursing career ladders.

**This study was undertaken in the month of February 1971. The Public

CAREERS LADDERS

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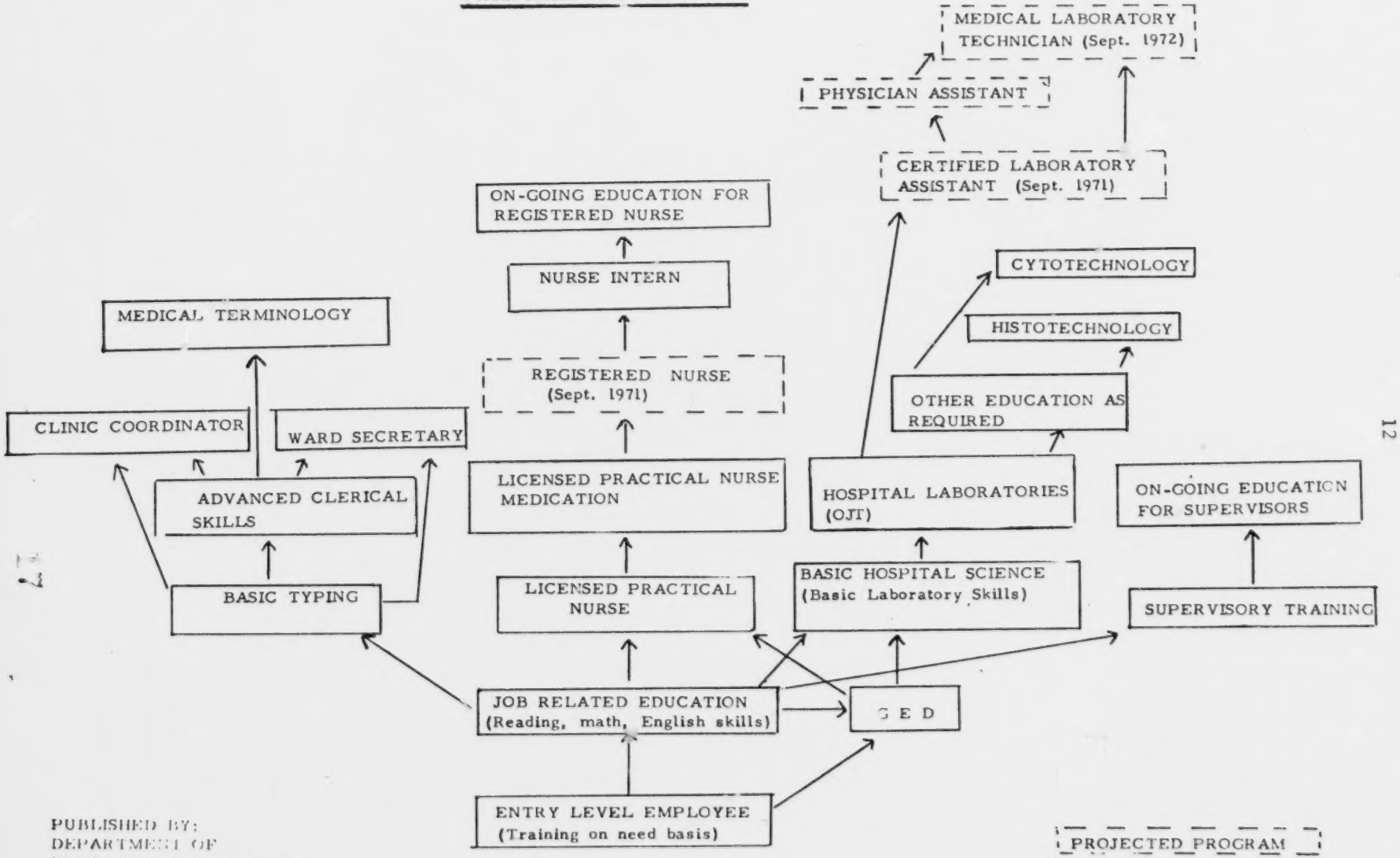
HOSPITALS AND CLINICS



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feasibility of establishing a human services vacancy reporting system in the Chicago area. Our purpose in this study was to examine:

(1) The need for such a system of reporting and the uses to which data collected could reasonably and profitably be assigned;

(2) The facilities and resources available to establish such a system; and

(3) The likely location, suggested method and other pertinent information concerning such a system that might be recommended.

In undertaking this study we were attempting to assess whether a vacancy reporting system in one community and in one job sector, the human services, might be a manageable undertaking, a first step toward supplying data of value to job analysts and job developers in the Employment Service, to the community colleges, the employing agencies and the manpower authorities in the City, County and State.

Following interviews with the key local agencies and a review of the literature dealing with vacancy reporting, we came to the following conclusions:

(a) Evidence indicates widespread consensus both nationally and in the Chicago area on this point, that job-vacancy data can be a valuable tool for manpower planning if handled and used properly. This is still largely opinion, however. No sparkling examples of ongoing operations or completed projects of this kind were available for us to examine. Proper handling and usage of this data remain without precise definition. Yet the need for a serviceable vehicle for manpower planning is so great and the prospects that job-vacancy data may provide such a vehicle so tempting, that the desirability of mounting a carefully conceived and planned project of this kind is undeniable.

(b) The question of its practical possibility, on the other hand, raises some spectres of methodology that have haunted more than one of the several authors who have become involved in such data-collection projects. If it is possible to collect and analyze job vacancy data in ways that are to be useful, certainly some pitfalls that have trapped others are to be avoided.

Service Institute was engaged to explore this question with the following agencies: City of Chicago, the Civil Service Commission and Mayor's Office of Manpower; Cook County, the Department of the Budget and Office of the County Clerk; State of Illinois, the Bureau of the Budget, the Commission on Urban Area Government, the Department of Labor, Bureau of Employment Security, the Department of Personnel and the Northeastern Illinois Planning Commission.

The first pitfall is in the method of collection. Reliance on mailed questionnaires has been disappointing. Reservations about this method were expressed frequently by persons contacted during the course of this study. Combined with an infrequent reporting interval, reliance on mailed questionnaires would no doubt prove ineffective.

On the other hand, the National Industrial Conference Board (NICB) conducted a pilot study financed by the Ford Foundation in the Rochester, New York SMSA in 1964, in which 27 business firms in the area were visited for the purpose of conducting in-depth interviews concerning job vacancies. The information developed from those interviews was valuable enough to persuade the NICB to undertake further such surveys on a large scale. The personal interview technique was to be applied in these large-scale studies.

(c) This leads directly to a discussion of additional difficulties, some of which became apparent to those who conducted the (NICB) study. One is the troublesome problem of defining a vacancy. The problem is somewhat different in government from what it is in a survey of private business, and if anything more complex. The fact that a job vacancy may be carried on the books for years and not be filled, perhaps not be recruited for, perhaps not be budgeted for in a given year, gives some indication of the dimensions of the question: "When is a vacancy not a vacancy?"

(d) Another problem is in identifying occupations properly from vacancy data pertaining to certain positions, and relating them to other occupations encountered in such a survey. The NICB study had serious definition problems using the Dictionary of Occupational Titles. One must anticipate greater difficulties in establishing similarities among human service occupations, where DOT designations are acknowledged to be not at all well developed when compared with the industrial sector.

All of this suggested that we might profitably begin with a pilot project aimed at collecting job vacancy data from a selected group of employers by face-to-face, in-depth interviewing, in order that the true picture of each organization with respect to job vacancies be ascertained. It further suggested that attempts to identify and classify occupations encountered in the survey in some systematic fashion had to be a companion effort if the data were to be useful.

2. Development of a Sub-Area Model for Health Manpower Planning

While the Center was exploring the feasibility of using a job vacancy reporting system as a tool for manpower planning, the Manpower Priorities Task Force of the Interim Organization was examining ways

in which Chicago area health manpower planning might be linked to the four sub-area comprehensive health planning organizations emerging in the city.*

In the dialogue which took place between the Task Force and the Center staff, these two efforts were coordinated in the spring of 1971. What became increasingly clear to both was that the community-based sub-area organizations have a strategic contribution to make in any health manpower planning system for a large metropolitan area such as Chicago.

The Manpower Priorities Task Force identified four major components of a manpower plan based on the active participation of the sub-area organizations:

a. Determination of Unmet Market Demand within Sub-Area for Allied Health Manpower

(1) Inventory of all health facilities; i.e., hospitals, nursing homes, group and solo practitioners, public health agencies, laboratories, clinics, etc.

(2) Employer demand survey of budgeted positions; data to include job titles, job descriptions, qualifications for positions, man hours required, salary or wages, turnover rates, numbers employed by category, number of vacancies.

b. Determination of Degree to which Effective Market Demand can be met from within Sub Area Manpower Pool

(1) Identification and evaluation of Sub-Area resources.

(a) Survey of sub-area community manpower pool; data to include basic demographic information, number employed, type of employment, characteristics, number employed in health field within the sub-area and outside the sub-area; number trained for health field, but unemployed, number of untrained unemployed and their characteristics, etc.

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*Under the Federal Partnership for Health Act and for purposes of comprehensive health planning, the Chicago Area has been divided into four sub-areas, each of which is responsible for organizing a broad community-based planning coalition. These organizations are expected to develop manpower plans and programs within the context of planning for comprehensive health care to residents in each sub-area.

(b) Inventory of training programs, both on the job and academic, within sub-area and outside the sub-area but available to residents, number of sub-area resident participants.

(2) Identification and evaluation of obstacles to fulfilling unmet market demand.

c. Projection of Future Demand for Allied Health Manpower beyond Current Unmet Market Demand

(1) Inventory of proposed new or expanded health facilities and estimated future need for allied health manpower.

(2) Estimates of future allied health manpower requirements of existing facilities.

d. Systemization of Sub-Area Resources and Elimination of Known Obstacles to Full Allied Health Manpower Employment

(1) Coordination, standardization and development of training programs.

(2) Development of on-going data base, employment registry and job bank to provide a standard reporting system for all hospitals, industry and training institutions.

(3) Development of community recruitment-outreach programs in each sub-area for allied health manpower training and placement.

3. Pilot Study of Hospital Job Vacancies

The Center and the task force are therefore presently engaged in an effort to identify hospital job vacancies within the Chicago metropolitan area, drawing wherever possible on the resources and commitment of the emerging sub-regional organizations. A survey questionnaire has been developed for use by the interviewers in their site visits to employers.*

Visits are being made to these employers, at which time they are requested to furnish class specifications or job descriptions of the various categories of workers they employ. Patterns of vacancies in the various job categories are being examined in the light

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*See Appendix III for Hospital Employment Survey questionnaire. In the case of smaller and outlying hospitals, the survey team has had to use mail and telephone interviews because of staff and time limitations.

of specific practices, budgetary situations, job definitions, recruitment patterns, practices of filling vacancies by promotion or by outside recruitment, qualifications required of applicants, salaries, turnover, working conditions and other relevant factors.

As these data are subject to analysis, we anticipate that patterns will emerge indicating peristent supply shortages or surpluses, movement in the demand curve and problem areas in the various occupational categories. Finally, the information collected ought to suggest underlying causes, remedies and specific plans of action which can be implemented to meet the need for allied health manpower in the Chicago area.

IV

BEYOND THE INTERIM

The future of the Interim Organization depends to a large extent on the following factors:

1. The ability of the Comprehensive Health Planning Agency to provide on-going staff support for sustaining the work of the Organization which has up to now been provided by the Center;

2. The development of operational linkages between the interim Organization and the new Chicago CAMPS organization which has responsibility for manpower planning and funding;

3. The decisions which the Interim Organization will make for itself in the coming year concerning its choices and options for a more permanent structure.

In the interim, it is clear that the Interim Organization has filled a vacuum, undertaken some significant tasks and provided a broad community base for future manpower planning and program development in the allied health occupations.

APPENDIX I

GUIDELINES
FOR
PHYSICIAN'S ASSISTANT PROGRAMS
IN ILLINOIS

recommended by

THE AD HOC COMMITTEE

jointly assembled by

THE ILLINOIS INTER-AGENCY TASK FORCE ON HEALTH MANPOWER

and

THE INTERIM ORGANIZATION
FOR CHICAGO AREA ALLIED HEALTH MANPOWER

OCTOBER 1971

INDIVIDUALS WHO PARTICIPATED IN ONE OR MORE SESSIONS OF THE AD HOC COMMITTEE

The following individuals made contributions to this guidelines document. The listing of an individual's name does not imply that he, or the organization with which he is affiliated, is in total agreement with the contents of this document. The Committee believes its product represents a working consensus rather than unanimity. Dissenting views were also invited and are appended to this report.

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GUIDELINES FOR PHYSICIAN'S ASSISTANT PROGRAMS IN ILLINOIS

I

STATEMENT OF PURPOSE

In developing these Guidelines for Physician's Assistant our first and major concern is to encourage programs designed to meet the health care needs of the people of Illinois.

We are also aware that the growing national and local interest in the training and utilization of Physician's Assistants makes it imperative for the State of Illinois to develop a coherent set of public policies with respect to this new source of health manpower. Since educational institutions, health care agencies and other governmental jurisdictions may also become directly involved in the training and/or utilization of these workers, it is essential that all such efforts be planned within the framework of a consistent set of agreed upon goals.

In the absence of such a commitment to collaboration, we run the risk of proliferating a disarray of poorly conceived programs which may become a liability both to the public and to the persons who seek career opportunities as Physician's Assistants.

It is with this concern for the public interest and for the maximum utilization of our human, educational and fiscal resources in Illinois that we have addressed

ourselves to the task of developing these proposed guidelines.

It was our purpose to affect as broad a consensus as possible among concerned agencies and organizations with respect to the major policy issues involved. We then propose to submit these recommendations to appropriate public and private agencies who are presently planning such programs or will have a direct interest in their implementation.

II

RATIONALE FOR THE PHYSICIAN'S ASSISTANT

We support the introduction of Physician's Assistant Programs in Illinois and encourage educators, health care practioners and health care institutions to begin collaborative planning and development of such programs.

In taking this position we wish to make it clear that we are unequivocally opposed to any programs which compromise the quality of medical care or set up a second class of health care services for poor people. Our support for Physician's Assistant Programs is based upon our conviction that the effective utilization of this new manpower will significantly improve the quality and accessibility of health care services available to the entire community.

We wish to emphasize, however, that the introduction of new manpower into our existing health care system will not in itself resolve the multitude of problems

we confront in providing adequate health care for all the people in Illinois. It has been demonstrated in many settings that, by employing allied health workers, it is possible to increase the number of patients served as well as to make more effective use of resources and skills available within the present health care delivery system. Programs which merely infuse additional workers into the present health care system do not, however, address themselves to the urgent need for re-examining and reorganizing the existing system.

In our judgment the optimum utilization of health manpower can best be achieved by effecting basic substantive changes in our health care delivery system. Only within a health care system which:

1. reorganizes its community health care resources to provide direct access to health care services for all persons in the community;

2. makes more rational use of all the scarce skills of its professional manpower; and

3. utilizes the full human potential of its allied health workers

will the Physician's Assistant, or any other health worker, make his optimal contribution. In a rational system of manpower utilization scarce professional skills will not be wasted on tasks which can be performed competently by lesser trained individuals. At the same time, every effort will be made to develop the full potential and maximize the contribution of workers at all levels.

We are witnessing at this time, both in Illinois and in the nation as a whole, the acceleration of efforts to re-examine and reorganize our health care delivery

system. While a consensus has not yet been achieved concerning the characteristics and components of a reorganized system of care, we anticipate that the emergence of a new health care system will be accompanied by the establishment of new health care institutions in new settings. Within this framework the present shortage and maldistribution of health manpower, which already presents a national emergency, will be intensified, particularly in disadvantaged inner city neighborhoods and rural areas. We look to the utilization of Physician's Assistants in these new health care institutions and settings as one way to help relieve both the manpower shortage and the maldistribution of health care personnel.

With the expansion of training opportunities, particularly at the community college level, we will also open for the first time a large new arena of job opportunities for persons who up to now have been excluded from any but the most low pay and low skill occupations in the health care field.

In summary, then, we support the training and utilization of Physician's Assistants for these reasons:

1. To produce some of the new manpower needed to provide full health care services and thus to facilitate the changes now occuring in the organization of the health care delivery system; and

2. to open up career opportunities in the health care field to large numbers of new workers presently excluded or underutilized.

III

ROLE OF THE PHYSICIAN'S ASSISTANT VIS-A-VIS THE PHYSICIAN AND OTHER HEALTH WORKERS

To make maximum use of the new manpower resources represented by the Physician's Assistant we will need to re-examine the functions performed both by the physicians and other workers employed in the existing health occupations.

In our task force discussions some concern was expressed with respect to how the Physician's Assistant functions will relate to the tasks performed by other workers. We wish first to emphasize that the use of Physician's Assistants is intended to fill a present manpower and service gap and not to replace other members of the health care team. We have also concluded that such questions as to what constitutes an appropriate division of labor, the issue of who has legal liability, who is superior and who subordinate in the work situation, along with other administrative matters, cannot be neatly defined or resolved in a general guidelines document.

These are matters which are best dealt with in the specific institutional setting. Their solution will depend upon the variables present in each situation; such as, the nature of a particular service program, the administrative style of its supervisors, the size and unique competencies of its staff. As we begin to develop some experience with this new member of the health care team, it will no doubt be possible to draw some general conclusions based on concrete observations about what works most effectively.

In the interim, it is evident that significant changes are already taking place in our concept of the physician's role as a result of the nationwide interest developing in a comprehensive health maintenance and medical care system. In the development of such a comprehensive health care system, the following examples are offered as illustrations of the functions which it is anticipated may be performed by Physician's Assistants and other allied health workers:

A. Development of the Data Base

The first step in the management of the healthy person or the sick patient is the development of the data base. There is considerable evidence as a result of a broadening body of experience that most of the health data base can be acquired in the absence of the physician. Furthermore, if we can agree on the content of the data base, it is likely that there will be more uniformity in its accrual in the absence of the physician.

In addition to performing tasks involved in eliciting a patient's medical history, assistants can also undertake tasks involved in making physical examinations. The introduction of multiphasic screening programs has demonstrated that deviant physical characteristics can be recognized in the absence of the physician. While alternate methodologies are now in actual use, with a little imagination and foreseeable technical advance, the range of possibilities in this area is enormous.

In summary, the important fact is that the history and those components of the

physical examination necessary for development of the health data base and recognition of normalcy can be done efficiently by non-physicians.

B. Health Education

Another aspect of preventive medicine and health maintenance in which the physician's role should be re-examined is health education. In dealing with such problems as cigarette smoking, obesity, problems of sexual inadequacy, the control of alcoholism or drug addiction, we have substantial evidence that the doctor-patient relationship has not been as effective in changing behavior as the mass media, the national publicity given to special reports and the activities of self-help groups.

Nevertheless, the need persists for more effective dissemination of basic health information to both well and sick populations. Non-physicians, collaborating with an individual doctor in his office or hospital setting, can be delegated tasks of providing basic information, counseling and support to clients on a one-to-one basis. They can also be utilized in group, family and neighborhood outreach programs contributing to the prevention of illness through instruction.

C. Other Preventive Maintenance Functions

Physician's Assistants may also perform certain positive acts of intervention such as routine immunization, prophylactic dental care and therapeutic dietetics in those cases where the risk factors are already identified. Increasing use of such

Physician's Assistants can also be made in diagnosis or, in broader terms, in the evaluation and management of patients.

In the ideal system, the data base including history, physical examination and routine laboratory measurements will have already been performed, recorded and retrieved when the person becomes a patient. But, there is no reason why the Physician's Assistant or the office or hospital computer terminal cannot perform this task if it is not already completed.

D. Primary Medical Care System

These tasks may include the sorting of patients and their problems in accordance with predefined criteria which will vary with circumstances and the specialty of the physician. This can include a) actual symptomatic therapy of minor or chronic disability such as the common cold or recurrent osteoarthritic pain; b) the broadening of the data base before the patient sees the physician by such acts as securing a throat culture, ordering a blood count or urinalysis, x-ray or electrocardiogram; or c) the establishment of temporal priorities for care and the referral elsewhere for care when appropriate. Assistants may also be assigned responsibility for the ongoing management of certain clinical categories. Examples include well-baby care, normal prenatal care and midwifery.

Other types of assistants will carry out technical aspects of the diagnostic and therapeutic process. Many of these are now functioning, but their scope of

activities will be broadened. These include 1) ophtalmological assistants; 2) orthopedic assistants; 3) coronary care assistants; 4) persons assisting in the emergency treatment of trauma and disaster victims on the trauma site, in a trauma center or hospital; 5) group therapists for patients with chronic, but stable diseases such as arthritis, neurological disability, diabetes, etc.; and 6) non-categorical specialists such as nutritionists, clinical pharmacists and nurse practitioners who will have new and expanded responsibilities for delivering various components of medical care management services.

The physician's role will be modified by the availability of the new technological tools provided by computers, general systems theory and industrial engineering techniques. Computers, for example, will relieve the physician of the necessity to rely on memory and will provide useful information to assist him in his decision-making process. The methodologies of the industrial engineer can help guide the diagnostic process in many categories of illness.

These methodologies are available to any physician. By following the recommended pathways, he can carry out a major part of the program in his own office with supplementary assistance provided by a central resource for those patients requiring the more complex techniques.

A final dimension of change in medical care management is being opened up by the communications media, including telemetry. These techniques are particularly

helpful in serving patients in remote and rural areas, for whom medical care is not presently available. Through the use of local human assistants and such technological supports, remotely located physicians should be able to direct the management of all people and to arrange for the transportation of those for whom only the physician's attention will suffice.

IV

DEFINITIONS OF TYPES AND ROLES OF PHYSICIAN'S ASSISTANTS

We have examined the definitions set forth by the National Academy of Sciences of the various types of Physician's Assistants. * While these definitions are clear, well stated and gaining considerable national acceptance, it is believed that certain qualifications and additions to these definitions are in order.

A. The Titles

We accept the terms Physician's Assistant and Physician's Associate somewhat reluctantly. It is true that many of these new workers will be used in settings where they will provide, along with others, direct assistance to a physician. However, in view of the tasks expected to be performed to an increasing extent by non-physicians in the emerging health care system, we have difficulty in justifying the terms Physician's Assistant and Physician's Associate for all of these workers. More appropriate titles might be Health Care Assistants and Health Care Associates,

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* See Appendix I for National Academy of Sciences' Definitions.

titles which describe more precisely the roles that large numbers of these workers will in fact be performing.

This is particularly the case with the Physician's Associate level. While we are aware that Physician's Assistants may to a large extent be employed by physicians and work directly under their immediate supervision, there is reason to assume that in the changing health care system, Associate level workers will begin to function in more autonomous professional roles. In the future Health Maintenance Organizations, for example, to which Governor Ogilvie in his recent health message has stated his commitment, it can be anticipated that Associate level workers will play a major role in health care management.

The categorization of workers as "Assistants" to a physician also creates unnecessary confusion and negative response among other health professionals and allied health workers, many of whom have provided varieties of "assistance" to the physician for many years.

The terms Physician's Assistant and Physician's Associate are also not congruent with the growing acceptance of the health care team concept, a concept which sees all members of the team as partners, working together and assisting one another. Furthermore, while health care teams in many settings will be under

the continuing full-time supervision of a physician, others in our changing health care system may be required to function with part-time physicians or consultant physicians available as needed by the team. It would seem inappropriate, therefore, to designate all of these new members of the health care team as "Physician's Assistants." For the same reasons, we do not totally accept the A, B and C classification categories used by the National Academy of Sciences. These designations do not add to our understanding of the various roles to be performed and imply a hierarchical order which adds to the confusion.

If we accept the National Academy of Sciences' use of the terms Physician's Assistant and Physician's Associate, therefore, we do so for two pragmatic reasons: 1) there is considerable advantage to going along with a national trend, in that persons trained under titles used exclusively in Illinois may experience difficulty in gaining acceptance elsewhere; and 2) the titles Physician's Assistant and Physician's Associate apparently serve as an attractive recruitment device to persons considering a career in this occupation. We would recommend, however, that the National Academy of Sciences and other concerned organizations consider the advisability in moving toward occupational titles which more accurately describe the total range of functions to be performed by these new members of the health care team.

B. Proposed Illinois Definitions*

THE PHYSICIAN'S ASSOCIATE

The Physician's Associate is capable of approaching the patient, collecting historical and physical data, organizing these data, and presenting them in such a way that the physician can visualize the medical problem and determine appropriate diagnostic or therapeutic steps. He is also capable of performing certain diagnostic and therapeutic procedures and co-ordinating the roles of other, more technical, assistants. While he functions under the general supervision and responsibility of the physician, he might, under special circumstances and under defined rules, perform without the immediate surveillance of the physician. He is thus distinguished by his ability to integrate and interpret findings on the basis of general medical knowledge and to exercise a degree of independent judgment.

THE BASIC PHYSICIAN'S ASSISTANT

The Basic Physician's Assistant employed by an individual physician, a group of physicians, or in a medical care setting supervised by physicians will function under the direct and continuing surveillance of the physician. His duties will be explicitly stated by the physician and the tasks delegated to him will be those which, in the judgment of the physician, can be competently performed by the Assistant. On the whole, the range of tasks will be diverse in nature and will reflect the scope and characteristics of the physician's practice and the medical care services provided in a specific setting. Basic Assistants employed in health maintenance settings may also function under the direct and continuing surveillance of those staff persons who are responsible for the administration and supervision of the health care services program, some of whom may be non-physicians.

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* These definitions are to a large extent based on the National Academy of Sciences' document on this subject. They are, however, revised to include certain modifications and additions proposed for use in Illinois.

THE SPECIALIST PHYSICIAN'S ASSISTANT

The Specialist Physician's Assistant is a worker trained to perform in one clinical specialty or, more commonly, in certain procedures within such a specialty. In his area of specialty, he has a degree of skill beyond that normally possessed by a Physician's Associate and perhaps beyond that normally possessed by physicians who are not engaged in the specialty. Because his knowledge and skill are limited to a particular specialty, he is less qualified for independent action in areas which do not pertain to that specialty. An example of this type of assistant might be one who is highly skilled in the physician's functions associated with a renal dialysis unit and who is capable of performing these functions as required. In all cases, the duties of the Specialist Physician's Assistant are implicit in his special set of skills; i.e., his training in a particular specialty circumscribes the range of his tasks. Within his own special skill area, however, he will frequently function with a considerable degree of responsibility and independence.

V

RECRUITMENT AND TRAINING OF THE PHYSICIAN'S ASSISTANT AND ASSOCIATE

A. Training Content

The content of any training program should be based upon at least three major factors: first, the nature of the employment setting, whether private practitioner, group practitioners, Neighborhood Health Centers, hospitals, clinics, etc.; second, the level of competency expected, whether technician, assistant or associate; and third, the level and extent of responsibility, ranging from total supervision to substantial independence of action.

For programs at both Assistant and Associate levels we encourage the schools to consider introducing a core curriculum, containing those basic courses which are generally applicable to the preparation of all allied health workers. It is highly desirable that the schools also develop some agreement as to the components of such a core curriculum, so that at least in Illinois the training completed in one school will be acceptable and accreditable in other sectors of the State.

This core will need to be supplemented, however, by special course work designed to prepare students to perform the specific work roles identified by potential employers collaborating with the school.

We recommend that no training programs be approved until reasonable efforts have been made by the training institution and potential employers of graduates to collaborate in the construction of such job descriptions which specify the nature and extent of the knowledge, competencies and skills required for actual job performance in the different settings and for the various categories of employment for which the training is being designed. Such occupational, job or task analysis will determine the amount, kind and time of the specialized training component and assure maximum "fit" between training and job performance. It is essential that the competency level be identified to the greatest extent possible before the educational level.

A large majority of the Committee also recommends that as much as possible of the

Physician's Assistant curriculum at the junior-community college level be devoted to occupationally relevant training, leaving certain selected liberal arts offerings to be acquired at later, different, or higher levels of education involving qualifications for conventional credentials.

B. The Education Ladder

A variety of educational settings are necessary to train Physician's Assistants and Physician's Associates, ranging from the community college to the medical school. The community colleges are urged to establish two-year Associate of Applied Science programs for both the Basic and Specialist Physician's Assistants. The four-year colleges and medical schools are urged to establish four-year programs for the training of Physician's Associates. In both cases, we strongly recommend that allied health workers with prior training and experience, including returning medical corpsmen, be permitted to enter these educational programs on an advanced placement basis, depending upon their individual competencies, through equivalency testing or other means.

C. Assurances to the Trainee

Educational institutions should be required to develop and establish experimental training designs in affiliation with quality clinical training institutions and are urged to build into their curricula four assurances on behalf of students: first, that jobs do in fact exist for the graduates of the program being planned; second,

that the curriculum result in bargainable and employable knowledge, competencies and skills; third, that the credential or degree awarded provide negotiable credit and advanced standing toward higher or different levels of work and responsibility within the categories of Physician's Assistant and other health professions and skills; and fourth, that trainees have the opportunity to be closely associated in training settings with physicians and other allied health workers.

D. Recruitment Priorities

Manpower needed for the medical-health field, including Physician's Assistants, must be sought from all possible sources. While members of existing allied health professions should have the option to enter this new profession, recruitment efforts should obviously be directed to expanding the available manpower pool by attracting new or inactive health workers into these programs. Equity and necessity also demand distinct efforts to recruit persons from the educationally and economically disadvantaged groups in the population. The junior-community college provides a major avenue of opportunity for such individuals for specific entry to the health fields through the occupation of Physician's Assistant.

VI

CAREER PATHWAYS FOR PHYSICIAN'S ASSISTANTS AND OTHER ALLIED HEALTH WORKERS

A. A Comprehensive View

In introducing the Physician's Assistant and Physician's Associate to the health care

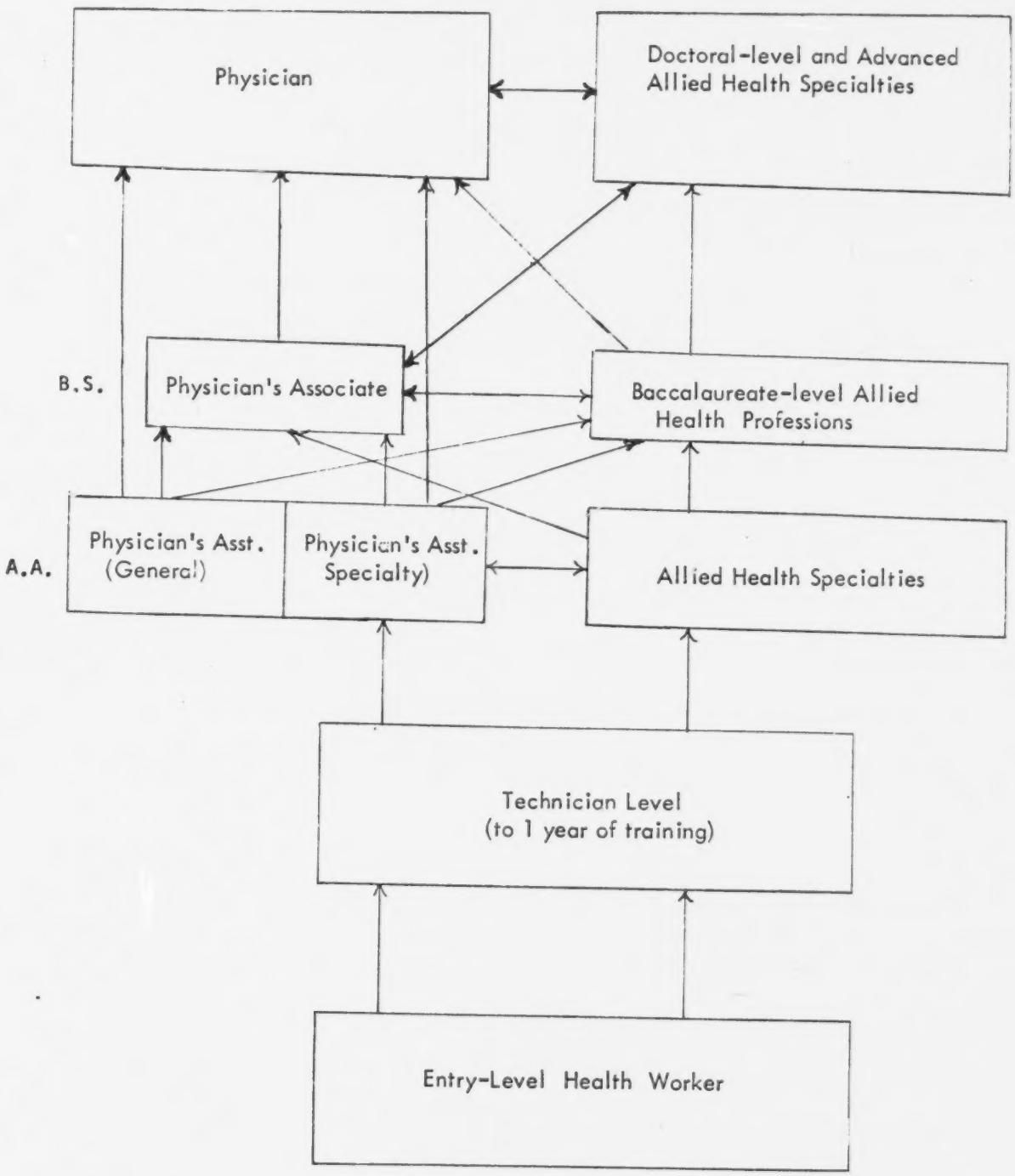
system in Illinois, it is essential to design both training programs and personnel structures in such a way as to broaden the career options and thus provide maximum occupational mobility for these new health care workers.

In undertaking this effort to integrate the planning of education ladders with job mobility ladders, however, we must be equally concerned with the needs of all those allied health workers who now find themselves with dead end training in dead end jobs and who seek opportunities for upward mobility.

We therefore propose that the problem be approached comprehensively, that we begin to design and implement a career mobility system which offers all allied health workers the opportunity to build incrementally on prior training and experience and to advance into more responsible and higher paying positions.

B. A Career Opportunity System

In the following diagram, we have illustrated how such a career opportunity system would operate to provide vertical and horizontal mobility to Physician's Assistants as well as to other allied health workers. From the unskilled manpower pool, workers recruited for the health occupations enter into training programs which prepare them to function in entry level positions. Completion of these training programs, including the G.E.D. preparation, ranging from several weeks to one year result in the award of a certificate by the high school



Model Career Pathways for Health Field with Physician's Assistant and Physician's Associate

or community college collaborating with the employer.

Workers are allowed release time to proceed from this level to complete work toward the Associate of Arts or Applied Science Degree, having been granted full credit through equivalency testing or articulation agreements for their prior training and experience.

Since the Physician's Assistant training program is seen as a two year course of study, students may include both new entries into the health care field as well as members of the existing allied health work force, including, for example, returning Medical Corpsmen. The Physician's Assistant Program itself provides two options: the Basic Physician's Assistant Course and the Specialist Physician's Assistant Course.

Persons who have completed a two year allied health program or its equivalent in prior training or experience should be able to proceed toward the Bachelor of Arts in the same fashion, adding whatever course work is required to perform competently at this work level. Persons entering Baccalaureate programs may choose from a number of career pathways to become Physician's Associates, Nurses, or other kinds of specialized health workers.

The same principle applies and the same opportunities are available for further training at the Doctoral level. In all cases, we anticipate that many workers will

be attracted to different and/or more challenging areas as they gain more exposure to the spectrum of opportunity available.

C. Preconditions for Success

The successful implementation of these career ladders and lattices is contingent upon close collaboration between employers and all sectors of the Illinois educational system, including the high schools, community colleges, four year colleges, universities and medical schools. Such collaboration is required to create the following preconditions for effective implementation:

1. That employers will negotiate with local educational institutions to integrate their in-service training programs with established educational curricula so that on-the-job training is fully accredited as part of the educational institution's certificate or degree program;

2. that local educational institutions and employers will make practical arrangements for employees to acquire the supplementary training not available through in-service programs, thus enabling workers to complete the academic work required for the award of a certificate or degree;

3. that educational institutions will fully accept and implement the practice of equivalency testing so that workers may proceed into advanced training programs without starting all over again; and

4. that educational institutions, employers and professional groups will recognize the common components of training implicit in the preparation of all allied health workers and proceed to design health core curricula at all educational levels.

In our judgment, implementation of this career system will also provide for greater efficiency in the management of the work force, particularly in situations where

(1) there is a regional surplus developed in a particular area; (2) there develops a need for new kinds of workers as a result of technological or delivery system change; and (3) when, as a result of such changes, certain professions or skills become obsolete.

VII

RECOMMENDATIONS RELATED TO ISSUES OF LICENSURE AND/OR CERTIFICATION

We are opposed to any measures at this time which may require mandatory licensure or certification of Physician's Assistants by State or local authorities for the following reasons.

1. It is in the public interest to stimulate and support broadly innovative approaches to the development and utilization of new manpower. Legal restrictions at this time may seriously inhibit the process of experimentation and testing out which are necessary if we are to explore new roles, functions and patterns of manpower utilization in the health care field.

2. Major national health organizations at this time are advocating a moratorium on moves to extend licensing or certification to new sectors of health manpower. This reflects the concern of both professional and lay groups with:

    a. the excessive legalized fragmentation of the health care occupations;

    b. the limitations placed by these regulations on the occupational and geographic mobility of health care workers; and

    c. the general lack of public and consumer representation on licensing boards throughout the country.

3. Far more effective controls to maintain the quality of health care can be built into the institutions responsible for the training of Physician's Assistants and into those settings which utilize them as members of the health care team.

4. It is unnecessary in this State to provide statutory authority for the use of Physician's Assistants, since the Illinois Medical Practices Act already gives the physician considerable latitude in delegating tasks under his "responsible supervision."

New Members of the Physician's Health Team:

PHYSICIAN'S ASSISTANTS

Report of the Ad Hoc Panel
on New Members of the Physician's
Health Team
of the
Board on Medicine
of the
National Academy of Sciences

1970

NATIONAL ACADEMY OF SCIENCES
2101 CONSTITUTION AVENUE
WASHINGTON, D. C. 20418

BOARD ON MEDICINE

May 13, 1970

Dr. Philip Handler
President
National Academy of Sciences

Dear Dr. Handler:

I am enclosing a report on a study conducted by the Panel of the Board on Medicine entitled, "New Members of the Physician's Health Team: The Physician's Assistant". The Panel was under the Chairmanship of Dr. Eugene A. Stead, Jr. The Board had an opportunity to review the study as it was in progress and has unanimously approved the final report. It should be emphasized that this study, which is planned as one of a series, is focused sharply on only one aspect of the broad subject of paraprofessionals in health services, namely on the so-called physician's assistant.

There are several reasons why the Board believes that there is a need for a statement on this question at this particular point in time: first, it is essential that flexibility be preserved in the development of the various types of physician's assistants, yet already attempts are being made to embody fixed criteria into state licensure procedures; second, despite all the publicity given to the concept of the physician's assistant, it is essential that authoritative groups, speaking from a strong medical base, lend sanction to the development; and, third, considerable interest has been expressed by the Departments of Health, Education, and Welfare and Defense in the subject of new type careers in health care for returning veterans with experience as medical corpsmen. The Board believes that the present report represents an excellent definition of the overall problem and characterization of the broad alternatives.

Sincerely yours,

Walsh McDermott, M.D.
Chairman

Enclosure

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GENERAL BACKGROUND

The Board on Medicine of the National Academy of Sciences is continually searching for "points of leverage" in the health field at which modest investments of energy and money can result in substantial improvements in the delivery of health care to the American people. Health care involves many professions and institutions, including several different types of delivery systems. One such system, and unquestionably the one most familiar to the public, is the system for the delivery of personal health services. These personal services are given largely by physicians, nurses, and various other personnel, but only the physician is equipped by education and training for certain critical roles.

In recent years and largely as a consequence of developments in biomedical research, the radius over which the physician can exert his influence has been steadily shortened. He can do far more things, but he does them for fewer people. Some means of compensating this situation must be found if the goal of satisfactory medical services for all is to be met.

The Board on Medicine believes that the development of better clinical support systems to help the physician deliver personal health care to deliver more units of personal health service per hour of his working day are now in the offing. In developing such systems, it is important to preserve sufficient flexibility to permit continued innovation and experimentation. One threat to such continued flexibility would be the premature incorporation into licensure laws of the job qualifications of various types of new health workers. One of the purposes of this report, which presumably will be one of a series, is to call attention to this danger. The principal focus of the report is on one of the possible new types of health workers, specifically on those that serve as immediate "extensions" of the physician.

It is anticipated that the new health personnel in general, and the systems they will man, will include various combinations of traditional personnel—physicians, nurses, dietitians, and others; new machines—computers, autoanalyzers, biomedical instrumentation; and new types of assistants, including those working at the physician-patient interface. Assistants of this last type*—the type discussed in the present report—differ from other health-related personnel in that they are selected by physicians, trained by physicians, and report administratively directly to physicians. They serve to extend the arms, legs, and brains of the physician. They interact at the physician-patient interface and are capable, under the direction of the physician, of performing functions now usually performed by physicians.

*Fixed titles for the different categories of assistants described in this report have not been established. There are indications that the Type A assistants described in this report will be called physicians' associates.

Another reason for examining this question at this time is that the armed services are returning to civilian life large numbers of men who have worked effectively in the military medical corps; the Departments of Defense and Health, Education, and Welfare are looking for guidance in determining effective ways to open up careers in the health field for these veterans. One way would appear to be the development of these new assistants. The Board believes that, along with expansion of the functions of other health professions, the use of these new assistants will permit development of new patterns of medical practice, and that the impact of new alignments of functions and newly trained people will be as immediate as that of new institutional forms and new machines. For these several reasons, therefore, the Board formed a panel to examine (1) the factors leading to development of these new assistants, and (2) the relationships between these assistants and the personnel who have traditionally helped the physician. The results of the study, which was reviewed by the full Board at several stages, are presented in this report.

THE NEED FOR NEW PERSONNEL

The current output of medical schools, plus the output of new and expanded schools, will be insufficient to provide personal health services to those segments of society now being served, while extending services to those segments now receiving little or no care.

Even if sufficient expansion of physician output to meet the total need for services could be achieved, it is doubtful that this expansion would be a wise course, since certain tasks do not require the unique talents of the physician and may be effectively performed by personnel with less total training, at less cost to the consumer.

Personnel in the existing manpower categories (such as professional nurses and physical therapists) could assume many health-service functions with added training, but should not be considered as the sole or even primary pool supplying personnel to these new health professions. A new primary pathway into the new class of physician's assistantships would tend to extend the range of health careers and would enhance the potential for recruitment of male as well as female candidates.

TYPES OF PHYSICIAN'S ASSISTANTS

In view of the great variety of functions of physicians' assistants, the variety of circumstances in which these functions might be performed, and the different sorts of skills and knowledge necessary to perform them, it is neces-

sary to describe several types of physician's assistants. These types are distinguished primarily by the nature of the service each is best equipped to render by virtue of the depth and breadth of their medical knowledge and experience. The Type A assistants are new to the American scene. Types B and C assistants have been present in one form or another for a number of years.

CATEGORIES OF PHYSICIAN'S ASSISTANTS

The Type A Assistant

The Type A assistant is capable of approaching the patient, collecting historical and physical data, organizing these data, and presenting them in such a way that the physician can visualize the medical problem and determine appropriate diagnostic or therapeutic steps. He is also capable of assisting the physician by performing diagnostic and therapeutic procedures and coordinating the roles of other, more technical, assistants. While he functions under the general supervision and responsibility of the physician, he might, under special circumstances and under defined rules, perform without the immediate surveillance of the physician. He is, thus, distinguished by his ability to integrate and interpret findings on the basis of general medical knowledge and to exercise a degree of independent judgment.

The Type B Assistant

The Type B assistant while not equipped with general knowledge and skills relative to the whole range of medical care, possesses exceptional skill in one clinical specialty or, more commonly, in certain procedures within such a specialty. In his area of specialty, he has a degree of skill beyond that normally possessed by a Type A assistant and perhaps beyond that normally possessed by physicians who are not engaged in the specialty. Because his knowledge and skill are limited to a particular specialty, he is less qualified for independent action. An example of this type of assistant might be one who is highly skilled in the physician's functions associated with a renal dialysis unit and who is capable of performing these functions as required.

The Type C Assistant

The Type C assistant is capable of performing a variety of tasks over the whole range of medical care under the supervision of a physician, although he does not possess the level of medical knowledge necessary to integrate and interpret findings. He is similar to a Type A assistant in the number of areas in which he can perform but he cannot exercise the degree of independent

synthes s and judgment of which Type A is capable. This type of assistant would l e to medicine what the practical nurse is to nursing.

Presumably these new health careers would be open to members of either sex. Although practical nursing has in the past been a predominantly female occupation, some medical corpsmen, as they re-enter civilian life and seek careers in the health field, are taking the licensing exam and becoming practical nurses. There is no basis for preference for either sex relative to any of the assistant types described here.

As far as can be foreseen into the future, these assistants should perform as members of a health team under the general supervision and authority of a physician or group of physicians. The provision that they should perform in a dependent relationship with physicians in fact expands the range of functions that are or may come to be within their individual spheres of competence. Of the various independent practitioners in the health field, only the physician is authorized to perform independently over the full range of medical care. The more narrowly defined spheres of activity of other practitioners are likely to influence strongly, if not firmly dictate, the limit of their functions and development – if for no other reason than that they bear so heavily on the nature of the problems that will be presented to them. On the other hand, assisting with the variety of problems that confront physicians over time provides opportunities for continuous learning and encourages the development of new skills that would justify "rising ceilings" on the activities and careers of exceptionally able assistants.

The functions performed by such assistants should be within the scope of medical competence of the physicians under whom they work. For example, it would be inappropriate for a surgeon's assistant to perform a preoperative cardiac evaluation unless the surgeon is competent to review his work critically.

Some assistants may wish to become independent, and they may do so by obtaining an M.D. degree. On the basis of performance and equivalency exams they may demonstrate that they have mastered many of the functions and concepts normally taught medical students in their clinical years. Type A assistants should be able to go through medical school in less than the usual four academic years.

GENERAL RECOMMENDATIONS RELATIVE TO EDUCATION AND TRAINING

The Type A Assistant

For proper performance of the functions outlined for Type A assistants, the student must be able to use written and spoken language in effective communication with patients, physicians, and others. He must also possess

quantification skills to ensure proper calculation and interpretation of tests. He must also meet high ethical and moral standards. Because of the nature of the activities of Type A assistants, large investment of time by physicians is required for their training. Obviously, it would be wasteful to invest this valuable commodity in candidates who do not demonstrate ability to learn rapidly and who do not have exceptional enthusiasm for careers utilizing this knowledge and training. Every effort should be made to ensure that candidates accepted for training possess these abilities and characteristics.

The essential educational requirement for Type A assistants is the equivalent of two years of professional-level training in classroom and clinical work. Many candidates for Type A programs are likely to have completed the first two years of college. It should be emphasized, however, that a college background is not considered necessary for entry into a Type A training program or for the effective performance of the functions of a Type A assistant. The level of general education represented by a high school diploma should be adequate pre-professional education for a Type A, as well as Type B or C, assistant. The Type A assistant will work closely with physicians and other health professionals, most of whom will have a degree of some kind. For this reason, the assistant may feel more comfortable if he has a degree. Provision should be made, where possible, for those completing a Type A program to earn baccalaureate degrees if they so choose, either by applying their professional training toward completion of their previous college work or by completing the pre-professional college courses at a later time.

The critical requirement for admission to a Type A training program should be the candidate's demonstration that he possesses the abilities and characteristics called for above. The following illustrative examples may serve the purpose of establishing the necessary qualifications for admission to a program and are provided as guides:

1. For Degree-Granting Programs: A candidate may be selected for the professional portion of the training following successful completion of the first two years of course work required by an affiliated college or university as a part of qualification for a baccalaureate degree.

2. For Non-Degree (Certificate) Programs:

a. A candidate may be selected if he has a high school diploma or its equivalent and can furnish appropriate assurances of his character and commitment. Experience has demonstrated that among the most reliable indications that a candidate possesses the necessary intangible characteristics is a showing that he has background experience in health-related work, including education and experience in direct patient care, and statements of evaluation from physicians or others competent to evaluate the qualifications cited above.

b. A candidate may be selected upon a showing that he has a speci-

fied number of years experience as a Type B or C assistant, and evaluation statements from those responsible for his work.

The curriculum of a program training Type A assistants should include adequate instruction in the basic sciences underlying medical practice and sufficient exposure to clinical medicine to ensure understanding of patients, their ailments, and the diagnostic and therapeutic responses to those ailments. Thus, students must be given adequate exposure to physician instructors and to clinical training essentially the same as that given medical students. The Type A assistant will generally have four types of training: 1) basic general education; 2) basic scientific education; 3) general clinical training; 4) specialized clinical training in some aspect or aspects of medical practice. The first two types of training may be available at a variety of institutions, including junior and four-year colleges. Because of the amount of physician time necessary for the third and fourth types of training, however, it is unlikely that it will be economically feasible to provide it except in hospitals associated with medical schools and other institutions participating in the training of physicians.

Persons entering a program who have already acquired clinical knowledge should be given appropriate credit.

The Type B Assistant

As for Type A assistants, the training of Type B assistants will require considerable participation by physicians. A significant portion of this training should be by physicians specializing in the area of the assistant's concentration because the Type B assistant will have a specialized skill in excess of that generally possessed by the ordinary physician. Because of the different nature of their activity, requiring less independence, the general education and clinical backgrounds of Type B assistants, of course, need not be as extensive as is suggested for Type A above.

Because of the specialized nature of the work and the narrow range of activity of a Type B assistant, the length of training required will tend to be more variable than for a Type A assistant.

The Type C Assistant

Type C assistants, because they are non-specialized personnel, require less general education, basic scientific education, clinical training, and special-skill training than is necessary for Type A or Type B assistants. A larger portion of their training might be given outside a medical center, and much of their clinical training could be given on the job. The training programs for practical nurses usually provide the type of preparation necessary for performance of the duties of Type C assistants. Recognizing that Type C assistants may wish to become Type A or Type B, educational programs for Type

A and B assistants should give credit for appropriate educational and work experience acquired in Type C training. This and other provision for upward mobility is of great importance and should be built into the system.

ACCREDITATION

Accreditation of programs should be in the hands of an accrediting agency. In medical education, this task has traditionally been performed under the auspices of the American Medical Association and the American Association of Medical Colleges, and it would be appropriate for these two organizations to establish the basis for review and approval of programs for the training of assistants.

In establishing criteria for entry into and mobility between groups of assistants, consideration should be given to proven competence as well as academic credentials. The accrediting agency should be aware of the fact that it is possible to establish the clinical and specialized skills of all three types of assistants starting with the basic background of a high school education. Recognizing that a non-degree (certificate) graduate may wish to achieve a baccalaureate degree later, it is urged that colleges consider a reversal of the usual sequence, permitting the professional courses to apply toward the degree, if the required pre-professional courses are completed later. The panel emphasizes that the success of this new concept in development of health personnel will depend in large measure on the flexibility of the approach of the accrediting agency.

LEGAL AUTHORIZATION

The need for development of professional quality control through an accreditation mechanism is accompanied by the need to provide legal authorization for the use of these new types of assistants. Such authorization must derive from the individual states, which have traditionally provided the legal framework under which health care is delivered.

It should be emphasized that these types of assistants are unique in the medical field, and the extent of their potential contribution has not yet been determined. Because of its desire to preserve the flexibility necessary for the optimal use and full development of the individual assistant's capabilities, the panel feels that legal authorization should not be effected through licensure. A type of authorization built around a system of registration could be developed, which would permit qualified physicians to employ assistants if such assistants have completed an approved program or have otherwise established their qualifications to perform the duties proposed for them. The basic objective should be to provide guarantees of the qualifications of personnel without imposing the rigid definitions characteristic of licensing legislation.

FUTURE IMPACT

Rapid strides have been made in recent years in expanding the scientific and technological knowledge that underlies medical care. Before the full potential of these advances can be realized, however, some resolution of the problems of physician shortage and maldistribution of medical care must be found. Discussions regarding the future of medical practice eventually lead to the conclusion that there must be major changes in the organization of health care delivery. Most such discussions lead to the conclusion that medical care must be organized into modes of service in which functions are coordinated and services rendered in such a way as to promote efficiency, convenience, continuity, and economy. Critical to the necessary reorganization is the utilization of different types of health care personnel.

Any mode of service developed must be capable of providing medical care to the many rural areas and depressed urban areas that are unable to attract and hold physicians. Technical interfaces, such as image transmission, might be developed to expand the physician's range of control and permit him to supervise an assistant physically separated from him. Skilled assistants will be needed to gather physical data, communicate it to the physician effectively, and administer the treatment prescribed by the distant physician. In addition, there is currently some speculation as to whether persons other than physicians might be able to act with some degree of independence in handling the more routine health problems in medically deprived areas. The development of assistants, such as those described herein, would contribute to the needed manpower pool and would provide an opportunity for experimentation with various combinations of personnel and technological advances.

CONCLUSION

There has been much discussion of health manpower needs and of roles for new types of personnel, such as physician's assistants. There is a need for objective data, including measurements of the effect of such assistants on the quality and quantity of medical care delivered in various settings. This task cannot be accomplished unless health personnel are trained and placed in practice settings in sufficient quantity to allow reliable observations to be made.

Although there are still unanswered questions and unresolved problems, the existing and still-growing shortage of physicians places programs for training physician's assistants among the top priorities for the health professions. The Board on Medicine endorses the concept of expansion of physician services by the use of physician's assistants, endorses and supports continued exploration of the effects of such assistants in a variety of clinical settings, and urges the cooperation of the Association of American Medical

Colleges, the American Medical Association, and government in the establishment and review of educational standards for training programs, the resolution of legal difficulties, and the establishment of uniform systems for testing and certification of such assistants.

ILLINOIS REGIONAL MEDICAL PROGRAM

Motion adopted by the Regional Advisory Group on March 22, 1971:

WHEREAS there is a need for greatly increasing the numbers and types of quality health personnel, including the need to utilize the returning armed forces personnel, and

WHEREAS many responsible educational institutions and agencies have undertaken the tasks of educating these new personnel without central coordination of these activities, and

WHEREAS premature introduction of licensure and certification may impede experimentation and development of new types of personnel,

THEREFORE BE IT RESOLVED THAT THE ILLINOIS REGIONAL MEDICAL PROGRAM

1. Supports the call for a moratorium on licensure and certification of health personnel until a concensus can be reached as to the responsibilities, functions, and relationships of such personnel, and

2. Supports and encourages the activities of the Illinois Interagency Task Force on Health Manpower in its efforts to resolve these issues and wishes to be kept informed of the progress of the task force.

ILLINOIS REGIONAL MEDICAL PROGRAM

Heart Disease, Cancer, and Stroke

Office of the Executive Director

122 South Michigan Avenue · Room 939/Chicago, Illinois 60603/Telephone 312-939-7307

July 13, 1971

TO: Regional Advisory Group
IRMP Task Forces and Committees

Physician's Assistants legislation failed to become law during this past session of the Illinois State Legislature. Nonetheless, many concerned individuals, including members of the Regional Advisory Group of the IRMP, feel that there should be a moratorium on any licensure or certification of Physician's Assistants and that the issue should not be revived when the Legislature meets in the fall.

At a recent business meeting, members of the RAG voiced support for the recommendations on Physician's Assistants made by the Ad Hoc Committee assembled by the Illinois Interagency and the Interim Organization for Chicago Area Allied Health Manpower. The Ad Hoc Committee's report, "Guidelines for Physician's Assistants Programs in Illinois," stated:

RECOMMENDATIONS
RELATED TO ISSUES OF LICENSURE AND/OR CERTIFICATION

We are opposed to any measures at this time which may require mandatory licensure or certification of Physician's Assistants by State or local authorities for the following reasons.

1. It is in the public interest to stimulate and support broadly innovative approaches to the development and utilization of new manpower. Legal restrictions at this time may seriously inhibit the process of experimentation and testing out which are necessary if we are to explore new roles, functions and patterns of manpower utilization in the health care field.

2. Major national health organizations at this time are advocating a moratorium on moves to extend licensing or

certification to new sectors of health manpower. This reflects the concern of both professional and lay groups with:

a. the excessive legalized fragmentation of the health care occupations;

b. the limitations placed by these regulations on the occupational and geographic mobility of health care workers; and

c. the general lack of public and consumer representation on licensing boards throughout the country.

3. Far more effective controls to maintain the quality of health care can be built into the institutions responsible for the training of Physician's Assistants and into those settings which utilize them as members of the health care team.

4. It is unnecessary in this State to provide statutory authority for the use of Physician's Assistants, since the Illinois Medical Practices Act already gives the physician considerable latitude in delegating tasks under his "responsible supervision."

The action taken by individuals on the RAG should not be interpreted as IRMP opposition to the Physician's Assistant concept. Quite the contrary. IRMP does not wish the development of Physician's Assistants to be inhibited by premature and restrictive licensure or certification requirements.

Individuals are urged to write to their State Legislators and express their views on this important issue.

cjs

ILLINOIS INTERAGENCY TASK FORCE ON HEALTH MANPOWER

March 31, 1971

FROM: Illinois Interagency Task Force on Health Manpower
Don C. Frey, Chairman

TO: Members of the Illinois Legislature

The Illinois Interagency Task Force on Health Manpower is a voluntary group co-sponsored by Comprehensive Health Planning, Inc. of Metropolitan Chicago, Health Careers Council of Illinois, Health Education Commission of the Illinois Board of Higher Education, Illinois Regional Medical Program and the State of Illinois Office of Comprehensive Health Planning. Its membership also includes representation from various professional organizations and other agencies concerned with health manpower in the State. The Interagency group hopes to serve a coordinating role in health manpower activities and believes that by merging the activities of these various groups it will minimize duplication of effort, yet have maximum impact in the health manpower field. A membership list is attached.

At its last meeting the Task Force voted unanimously in support of a moratorium on licensure of new health occupations. In essense, we agree with the recent positions of the American Medical Association, the American Hospital Association, and the Congress, who, in viewing the confusing status of health fields licensure, recommended a moratorium on new legislation until an effective assessment of the entire licensure question can be developed. The time limit on the moratorium should extend at least through the current legislative session. Moreover, because there are no physician's assistant programs currently in Illinois, an ad hoc committee has been formed and is drawing up guidelines in order to provide substantive guidance to groups developing such programs.

Finally, some of the issues related to physician's assistants that need collaborative decision before legislative action is taken are as follows: there must be agreement on the requirement for task analysis, definition of roles, educational experience, alternate pathways, states of dependency and independency, licensure and certification, and the question as to whether these physician surrogates are being developed for the purpose of perpetuating the existing relationship of physician to patient population or as needed personnel for service in the changing health delivery system.

We hope this information will be of use to you. Please feel free to call upon the expertise represented by the Task Force, if we can be of assistance to you.

For further information contact:

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David M. Kinzer, executive vice president

June 4, 1971

Myrna B. Kassel, PhD
201 North Wells Street, Room 1700
Chicago, Illinois 60606

Dear Myrna

re: Guidelines for Physicians Assistant
Programs in Illinois

The adhoc committee's report is good reading and good quidance. I shall eagerly look forward to its consideration at the next meeting of the Interagency Task Force, June 15. (Incidentally, this is my first and only notification of the upcoming meeting.)

A few comments:

I would suggest inclusion of the IHA Manpower Resolution (1970) in support of the moratorium. It predates the AHA and AMA statements. Besides, it is Illinoisian and originates in the IHA Conference Group on Education.

I would appreciate a clearly stated caveat against training physicians assistants to become "doctors of the poor" or "country doctors" for rural Illinois. Much of the rational for PA prograns supports these inferences.

Finally, I would suggest broadening the generic meaning of "physicians assistant" by recognizing PA roles for others, especially registered and licensed practical nurses, and for registered pharmacists. I will let you worry about stating when the role is "associate"or "assistant".

Sincerely

David W. Stickney
Associate Director

DWS:ngr

Memorandum

840 NORTH LAKE SHORE DRIVE • CHICAGO, ILLINOIS 60611 • 312/664-9500

July 8, 1971

TO : Administrators of Member Hospitals

SUBJECT: PHYSICIANS' ASSISTANTS

The attached document is prepared for guidance of Illinois hospitals, their administrations and medical staffs. It applies to any physician's assistant -- regardless of his title -- while working in the hospital fulltime or part-time under a physician's supervision. It applies whether the assistant is paid by the physician or the hospital and whether or not he has graduated from an established educational program for physicians' assistants.

The recommendations in the document are based upon the thesis developed over the past 15 months by IHA's Conference Group on Education, chaired by Joseph P. Greer of Children's Memorial Hospital, Chicago. Consideration of the emerging physicians' assistants category in hospitals has been a part of the conference group's broad study of health manpower, education and licensure, and of the group's plea for the licensure moratorium endorsed by the IHA membership at the 1970 Annual Meeting.

David W. Stickney
Associate Director

7/8/71:bjs

ILLINOIS HOSPITAL ASSOCIATION

840 NORTH LAKE SHORE DRIVE • CHICAGO, ILLINOIS 60611 • 312/664-9500

Document

PHYSICIANS' ASSISTANTS IN ILLINOIS HOSPITALS

The Illinois Hospital Association and its Conference Group on Education believe that physicians' assistants can have important roles in hospitals. They can expand a hospital's capacity to deliver patient care and, to quote a statement of the National Academy of Science, "they serve to extend the arms, legs and brains of the physician."

There is no Illinois statute dealing specifically with "physicians' assistants," but IHA believes they are legal like dozens of other job categories as long as the hospitals in which they work are deliberately careful to safeguard patients. Such care is the subject of this IHA statement. The Illinois law which IHA has reviewed includes the State Supreme Court decision in Darling vs. Charleston Community Memorial Hospital (1965), the Medical Practice Act and the other health occupation licensure statutes, and the Illinois Hospital Licensing Act and Requirements. IHA also believes that physicians' assistants may be used within the standards of the Joint Commission on Accreditation of Hospitals effective July 1, 1971 (see Medical Staff, Standard VII and its Interpretation). Finally, if the hospital acts responsibly, there is no reason to expect any effect on the hospital's liability insurance.

Within this context, medical corpsmen being discharged from the armed services and the graduates of the nation's new physicians' assistants programs offer all hospitals an important new source of trained allied health manpower which should be utilized. Especially valuable are corpsmen who have completed one of the collegiate or university medical school physicians' assistants programs. (Hospitals are urged to utilize the placement service of the Health Careers Council of Illinois, for HCCI is the official Illinois agency for placing medical corpsmen in health jobs.)

Whether a hospital permits physicians' assistants to attend patients under the supervision of a member of its medical staff is for each to decide. This document is designed to assist in that decision and to help hospitals take the precautionary steps in creating and administering an appropriate job description.

IHA cautions that physicians' assistants must NOT be misused or abused or exploited. They must not be the excuse for a physician to practice less medicine or to practice less responsibly, nor an alternative to physician care of poor people or of people in downstate farm communities suffering from a shortage of MDs.

Definitions. "Physician's assistant" is a new term within the past two years, but it applies generically one time or another to many of the 20,000 RNs and 20,000 other people when working in Illinois hospitals under a physician's "supervision." There are nurse anesthetists, nurse aides, inhalation therapists, social workers, cast technicians, brace makers and prosthetists, medical technologists, occupational therapists, physical therapists, technicians on kidney dialysis machines and other technicians on heart pumps, etc., etc. Only a few in this list are licensed occupations. Obviously a physician's assistant may not practice a licensed vocation unless licensed in that vocation. He cannot practice medicine or professional nursing, for example.

Narrowly, the term applies to graduates -- mostly male and military corpsmen -- of a great variety of "physicians' assistants programs." Examples include the eight-week program at Johns Hopkins Hospital, three months of classroom plus 12 months preceptorship with a GP in his rural practice in the MEDEX program of the University of Washington Medical School, two years at the Duke University Medical School, and five years in the University of Colorado baccalaureate program for child health associates.

Neither of the physicians' assistants licensure-certification bills before the first 1971 session of the Illinois General Assembly was passed -- H-203 was defeated and S-24 is on postponed consideration. Neither bill contained a useful definition. The fact is that there is no accepted definition beyond the requirement that physicians' assistants work under the supervision of a physician. There are no universally accepted guidelines on the sort of work physicians' assistants can do and when it must be performed in the presence of the supervising physician. The effect is to leave it to hospitals individually to define their own meaning of the term by composing job descriptions.

Complementary definition: the supervising physician. Essential in any description of a physician's assistant is a description of the licensed physician who has qualified himself to "supervise" and "direct" assistants. There has been too little consideration of this factor. California's physician's assistant law certifies that the applicant physician is qualified to supervise, but does not certify or license the assistant himself. The application of this notion to Illinois is that any hospital medical staff member who would supervise physicians' assistants in the hospital should be required first to learn about the curricula his assistants have studied, their training and skills, and the judgmental aptitudes of each. Also, the supervising physician should satisfy himself that assistants he supervises have had sufficient training for any new tasks he will ask them to perform. This is an important principle, according to IHA legal counsel Harry L. Kinser.

A decision for hospitals individually. IHA believes that hospitals individually have the authority to decide whether physicians' assistants in the 1971 meaning of the term -- graduates of organized collegiate programs -- shall or shall not be permitted to care for the hospital's patients and to define the privileges and restrictions applicable to each assistant and to his supervising physician. IHA further believes that the decision is one to be initiated by the medical staff with the advice of administration and consent of the governing board. These decisions should be made in the light of the Darling case, namely, a hospital (its governing boards, medical staff, administration and operating staff) is legally responsible for patient care. It was no defense for the hospital that the physician who handled Darling's compound fracture was fully licensed nor that he was not an employee of the Charleston hospital.

Hospitals using physicians' assistants. These guidelines are in four steps and apply regardless of who pays the physician's assistant and whether he works fulltime or parttime in the hospital.

1. Job description

   The supervising physician(s) should draft a job description (usually with help of the hospital's personnel department) which includes:

   a. Job or functions to be performed. Be definite. "...And any other duties the supervising physician may order" is a vague function and unacceptable. There will be "sticky" questions -- Can he write "orders" and under what conditions? What technical diagnostic and therapeutic procedures

may he perform? What functions may be performed only in the physical presence of the supervising physician? How will the assistant relate with others, especially with RNs?, etc. Finally, what are the qualifications of medical staff members who shall be permitted to supervise assistants?

b. Education, training and experience required to qualify the assistant to perform the job.

2. Medical staff acceptance

The medical staff should consider the proposed job description, amend it if necessary, and formally accept or reject it as a matter of minuted record. The staff should also consider whether the new job category requires any modifications of the staff's own by-laws, rules or regulations.

3. Establishment of job description

Administration should acknowledge receipt of the job description, adopt it with appropriate wage-salary ranges in the personnel schedule of the hospital and secure the board's formal approval or at least clear with the board president. Then administration should establish the new position in the hospital's personnel process, and announce it to the hospital's operating staff through the routine procedure. It should be available for inspection by surveyors along with other personnel records.

4. Administration of the new job

The hospital's administration and medical staff must comply with the new job description.

The strongest court defense to a personal injury lawsuit arising from physicians' assistants will be the record of deliberate care in establishing the job description and evidence that the hospital and its physicians faithfully administered it.

IHA maintains a file on "physicians' assistants" working in Illinois hospitals, of their job descriptions and of whether the individuals are employed by physicians or the hospital. Please report your own hospital's practice.

David W. Stickney
Associate Director

6/9/71:bjs

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June 25, 1971

Mr. David Wandel
Administrative Assistant
Human Services Manpower Career Center
201 North Wells Street
Chicago, Illinois 60604

Dear Mr. Wandel:

I appreciate your forwarding to us copies of the "Interim Organization Chicago Area Allied Health Manpower Statement of Objectives" and the "Illinois Guidelines for Physician's Assistants," and "Barrier Removal Document."

I would be most interested in being considered as a representative or a consultant to your group. It would be most valuable in keeping me abreast as to local organization of allied health manpower and manpower utilization.

I find your organizational concept for Chicago Area Allied Health Manpower both well conceived and specific in objectives. With respect to the "Guidelines for Physician Assistant Programs in Illinois," I find this document very comprehensive and thought-out, in most instances. I feel that the definitions of types and roles of Physician Assistants, as recommended in this Illinois Guideline, is an improvement over those of the National Academy of Sciences; however, there is still some room for confusion.

I would also like to point out that the term "Physician Assistant," as trained at Duke University, is now being entitled "Physician Associate," and an organization of these persons is being incorporated under this new title. A new Journal is being marketed entitled, "The Physician's Associate." If you are interested, contact Russel F. Lawrence, Editor "Physician's Associate," P.O. Box 2914 CHS, Duke University Medical Center, Durham, North Carolina 27706.

I am particularly pleased with the recommendations relative to issues of licensure and/or certification, since the functions, roles and responsibilities for these new allied health professionals have not been completely delineated or explored for acceptance and competency at this juncture.

With respect to the "25 Barriers Document," it is limited by the fact that it did not include the 26th Barrier, which is the human propensity to resist change. I believe it is still a mark of repute as well as moral stamina in the professions to prefer obsolescence. However, I do think that the barriers, the results, and the "we need" were well stated. I would merely point out that it is not too difficult to agree on what is needed, but extremely difficult to describe and set forth what we can do - which really amounts to the action part of overcoming the barriers. The document would have more usefulness if some suggestions of action or "what can be done" was added to each of the barrier items listed.

I appreciate your sharing this useful information, and if I can be of any further assistance as a representative or a consultant, please feel free to call me.

Sincerely yours,

Wesley J. Duiker

Wesley J. Duiker, Director
Office of Allied Health Manpower

WJD:ms

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July 1, 1971

Mr. Don Frey
Executive Director
Health Careers Council of Illinois
410 North Michigan Avenue
Chicago, Illinois 60611

Dear Don:

In keeping with a June 17, 1971 memo from Pat Brown, Secretary, Illinois Interagency Task Force on Health Manpower, I am sending herein my comments on Guidelines for Physicians' Assistants in Illinois, to you.

First a general comment. As I look back on the development of assistant type categories of workers in other health professions, it is my impression that the professionals to be "assisted" took the leadership through their professional organizations and their education programs in planning, testing and implementing suitable educational programs and directions for practice of the graduates of those programs. This was certainly true in nursing, especially in relation to the development of practical nursing and associate degree nursing programs. Why is this not true of physicians and organized medicine in relation to "physicians' assistant" programs? I believe it is both desirable and essential.

Specific comments on the Guidelines:

1. How can a consistent set of agreed upon goals be established without some consensus from medical education or organized medicine about what they will be educated for?

2. Since it is fairly obvious that the maldistribution of physician manpower will continue, are physicians' assistants (who are not presently envisioned as professional level health workers) to relieve this maldistribution in disadvantaged inner city neighborhoods and rural areas? If not, what does the following statement (p.4) really mean: "We look to the utilization of Physicians' Assistants in these new health care institutions and settings as one way to help relieve both the manpower shortage and the maldistribution of health care personnel".

3. Illustrations of functions which it is anticipated can be performed by physicians' assistants (p.):

Development of the data base as described on p.6 could be done by nurses as they do a "nursing assessment" of the patient. Why introduce another worker who asks the same questions and makes the same appraisals -- perhaps not as skillfully as professional nurses could be taught to do it? Pity the poor defenseless patient!

Health education -- and utilizing the physician's assistant as described on p.7. Are you not expecting a great deal of this technical level worker? Why not utilize other already available professional health workers, and give those professionals the necessary continuing education opportunities to enable them to make this a regular part of their professional roles? This has never been the exclusive responsibility of physicians; nor should it be. Why introduce another type of health worker for this?

Other preventive maintenance functions:
The examples given are already the functions of nurses; dental assistants/hygienists; and nutritionists and nurses, respectively. If physicians really worked with present other members of the health team to plan for carrying out these responsibilities, the case for physicians' assistants (with less training and scientific knowledge than other health workers mentioned) would seem to be rather flimsy.

By this time you will have concluded that I am not enthused about the physicians' assistant or the Guidelines as presently conceived, therefore I shall not comment further. To me the concept of the role, functions and preparation of this new health worker is very fuzzy indeed. Therefore I believe that all efforts to support and/or promote educational programs and recruitment into them should be tabled until there is clear direction and committment from physicians and medical educators as to what functions they are being prepared for (and why).

Sincerely,

Kay Bailey

(Mrs.) Kathryn E. Bailey
Associate Executive Director

illinois nurses association

6 NORTH MICHIGAN AVENUE • CHICAGO, ILLINOIS 60602 • (312) 236-9708

May 7, 1971

Mr. Don Frey, Chairman of the Ad Hoc
Committee
Illinois Interagency Task Forece
410 North Michigan Avenue
Chicago, Illinois

Dear Mr. Frey:

I regret being unable to attend the final meeting of the Ad Hoc Committee on Physicians Assistants scheduled for May 11, 1971. However, since there will be no opportunity for further discussion anyway, I assume that a written statement from me will serve your purpose just as well.

Considering the document as a whole, it appears to be substantially the same as it was prior to the last meeting and therefore, many of the same objections I raised at that time still apply. These can be summarized as follows:

1). The roles ascribed to the physicians assistant and the definitions used to describe the various levels do not appear to clearly differentiate the physicians assistant from other health workers.

2). Section VI, related to career pathways seems to represent a philosophy for change rather than specific guidelines.

3) Section VII, also seems to represent a philosophy in general, rather than a guideline for licensure of physicians assistant in particular.

In view of the above objections, I am unwilling at this time to concur in the adoption of this document as a guideline for the introduction of physicians assistant programs in Illinois.

I would like to take this opportunity to thank you for allowing me to participate in these discussions.

Sincerely,

Joyce Taylor

(Mrs.) Joyce Taylor
Associate Administrator
Illinois Committee on Nursing Careers

JT:rt

Springfield Office: 101 South Fifth Street, Springfield 62701 (217) 523-0783

PHYSICIAN'S ASSISTANT JOB DESCRIPTION AND DUTIES AS USED IN ONE ILLINOIS HOSPITAL EMPLOYING PHYSICIAN'S ASSISTANTS

PHYSICIAN'S ASSISTANT

DISTINGUISHING FEATURES OF WORK:

Under direct supervision performs responsible patient care activities necessary in the care and treatment of patients. Assists physician in whatever manner he deems necessary for the particular patient being treated at the time. May assist the physician in certain specialty areas of care such as surgery, laboratory, or other specialty areas. May take medical history of patients for the physician's review and consideration.

ILLUSTRATIVE EXAMPLES OF WORK:

1. Provides patient care activities in conformance with recognized medical techniques and procedures in accord with the established Medical Staff By-Laws and the policies of the hospital.

2. May monitor patients post-operatively and reports complications to attending physician and assists with whatever remedial measures he indicates.

3. May perform suction-decompression of the stomach with nasogastic tube, urinary catheterization, starting and regulating intravenous therapy, care and removal of drains and tubes, and any other function that is deemed necessary in the physician's judgment.

4. May record medical histories of patients and prepare them for analysis by attending physician so that he may utilize them in the diagnosis and treatment of the patient.

5. Makes rounds with physicians, both pre-operatively and post-operatively, and assists physician with any special treatments and/or dressings.

6. Collects various samples for laboratory analysis, such as blood and urine and transmits them to the laboratory.

7. Administers medication prescribed by attending physician and observes and records such information regarding a patient's condition, such as temperature, pulse, respiration, and blood pressure.

8. Reports to physician on condition of patient and initiates emergency measures to counteract unfavorable symptoms such as the administration of oxygen, glucose or other measures as directed by the physician and in conformance with hospital policies.

9. Performs other duties as required or assigned.

DESIRABLE REQUIREMENTS:

Education:

Requires knowledge, skill and mental development equivalent to completion of four years of high school, supplemented by an acceptable training program comparable to the physician assistant program sponsored by Duke University or other acceptable and educational program as determined by the medical staff and the administration of the hospital.

Significant Responsibilities:

Requires ability to observe and report patient conditions to physician.
Requires ability to apply general patient care techniques and practices.
Requires ability to follow and give oral and written directions in exact detail.

TO: Health Manpower Leaders in Illinois

FROM: Illinois Interagency Task Force on Health Manpower
and
Interim Organization for Chicago Area Allied Health Manpower

This document represents several months of deliberation by an Ad Hoc Committee appointed by the Illinois Interagency Task Force on Health Manpower and the Interim Organization for Chicago Area Allied Health Manpower for consideration of what directions Physician's Assistant programs should take in Illinois.

For anyone contemplating the use or training of Physician's Assistants in Illinois, we believe this discussion will provide a fuller view of both the possibilities and the pitfalls present in this emerging occupation.

At the present moment, as indicated in this document, the term "Physician's Assistant" means many things to many people. And, given the present differing patterns of training and utilization, we don't anticipate a complete clarification of roles and the universal acceptance of this new category of health worker for several years at the minimum. Under these circumstances, therefore, the work of the Ad Hoc committee looks more important today than it did nine months ago.

This is not a set of guidelines to instant or even eventual full implementation of a Physician's Assistant program. It is a thorough discussion, however, by knowledgeable leaders of a potentially usable tool for dealing with the multi-faceted demand in the health care system in Illinois for Physician's Assistant specialists and generalists.

Physician's Assistant-Associate workers are needed and will be utilized, although not universally in all health care components. In many situations they will meet with rigid opposition for a variety of reasons, some laudable, others deplorable, considering present unmet health care needs.

If we were to have only one effect...to dispel the prevalent notion among most laymen, and too many persons in the health field, that the role of the Physician's Assistant is fully understood and accepted, then our effort will have been worthwhile.

The twenty-five individuals who participated in the dialogue (see page xxxii) which produced this report represented a variety of interests and concerns with respect to the training and/or utilization of Physician's Assistants. Their participation does not imply endorsement of the paper as a whole, and in fact there are a number of areas of divergent opinion, some of them noted in the text.

However, all of them shared a concern for the total subject, its immediacy and the need for a thoughtful approach to implementing any program in Illinois.

Circulation of the original "posture paper", now comprising the first part of the document, resulted in a number of interesting direct and tangential reactions which are reproduced in an Appendix. These range from the very concrete and objective set of guidelines from the Illinois Hospital Association for assisting their members in grappling with what can be a complex medical - legal problem to some highly abstract and subjective personal opinions which constitute, in our judgment, an image of a Physician's Assistant who never was and never will be.

We have included these materials because they represent either an important consideration affecting the eventual use of Physician's Assistants, something to be incorporated in the training cycle or conceptual framework, or a widely-held point of view, rational or irrational, of which trainers or users of Physician's Assistants should be aware.

In reading this document it is important to remember that we are still in an emergent and experimental situation. We will fulfill our multiple expectations only by keeping in mind that not everyone is interested in the Physician's Assistant for the same reasons.

The Ad Hoc committee itself had such diversity of aspiration. Its members included persons affiliated with:

> Health Service Institutions, looking to the PA as a means of relieving staff shortages and implementing new patterns of care.
>
> Educational Institutions, committed to developing viable training programs to meet health care needs.
>
> Manpower Organizations, motivated by the opportunity to provide jobs with genuine career advancement for new health care workers, and
>
> Professional Groups, concerned with ways in which the PA will affect the roles and responsibilities of other health workers.

Their dialogue is only a beginning. Many remaining issues and problems will only be resolved as actual programs emerge and Physician's Assistants are utilized in our changing health care system.

Don C. Frey, Chairman
Illinois Interagency Task Force on
Health Manpower
410 North Michigan Ave. Room 1044
Chicago, Illinois 60611

Myrna B. Kassel, Ph.D., Chairman
Interim Organization for Chicago
Area Allied Health Manpower
201 No. Wells St.-Room 1700
Chicago, Ill. 60606

APPENDIX II

TWENTY-FIVE BARRIERS

THAT RESTRICT THE EFFECTIVE RECRUITMENT, TRAINING AND UTILIZATION OF ALLIED HEALTH MANPOWER IN THE STATE OF ILLINOIS

August, 1971

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INTRODUCTION

In June of 1970 the Illinois State Employment Service, the Human Services Manpower Career Center, the Chicago Area Comprehensive Health Planning Agency, representatives of its sub-regional health planning organizations and the Chicago Department of Human Resources sponsored a conference to consider their mutual interest in developing an inter-agency consortium for program planning and manpower development in the allied health field. From this conference has evolved a partnership of thirty-nine agencies committed to working together to strengthen the planning, recruitment, training and utilization of allied health manpower in the Chicago Metropolitan Area.

From its inception the Interim Organization for Chicago Area Allied Health Manpower has recognized that certain education, administrative, economic and legal barriers exist which seriously inhibit the City of Chicago and other Illinois communities from dealing effectively with the allied health manpower crisis. At the first official meeting of the Interim Organization on November 2, 1970 the membership body created a task force to consider and recommend steps toward the removal of these barriers. Lou House, Executive Director for the Council for Bio-Medical Careers, agreed to serve as Chairman of this study group and was joined in this effort by Theresa White, Director of the Volunteer Bureau, Welfare Council of Metropolitan Chicago; Helen Dulick, Administrative Assistant of the North Suburban Association for Health Resources, Terry Donnelly, Associate Planner, Comprehensive Health Planning, Inc., and Thomas Marsh, a member of the staff of the Human Services Manpower Career Center.

Contributions to this study came from the following sources: 1) eighteen

persons selected by the task force on the basis of their comprehensive knowledge, experience and leadership in the Illinois health manpower field. Nine of these persons were personally interviewed; nine submitted written documents containing their views and recommendations. The names of these individuals are listed in Appendix I; 2) A study of the extensive literature dealing with this subject matter, selected references from which are contained in Appendix II.

During the five-month period in which this study was being completed, a consortium of State agencies and voluntary organizations concerned with health manpower came together to form the Illinois Inter-Agency Task Force on Health Manpower. This group, of which the Chicago Interim Organization is a member, undertook to identify its tasks and priorities. The product of this effort was a comprehensive inventory of the specific actions we need to take if we are to solve the most critical problems facing the State in the recruitment, training and utilization of health manpower. In completing this document, we have drawn upon the work of the Illinois Inter-Agency Task Force which is still in process. In virtually each case, we have been able to match the various barriers identified in our own study with the tasks set forth by the Illinois Inter-Agency Task Force. Both pieces of work, it has turned out, are highly congruent and reinforce one another.

On April 1, 1971, Governor Richard B. Ogilvie, in his health message to the General Assembly, called for

> " ...a moratorium on creating additional licensing and certification categories for health professions this year...I urge this Legislature to establish a commission with adequate appropriations to perform the evaluation and planning that is needed. This will include review of the existing laws, regulations and administrative procedures for licensure and certification. It will examine and recommend the relaxation of administrative regulations to remove existing barriers to competent individuals..."

On April 20th, the Illinois Inter-Agency Task Force on Health Manpower accepted the invitation of the Governor's Office of Comprehensive State Health Planning to collaborate in identifying specific ways in which the recruitment, training and effective utilization of health manpower can be strengthened now within present statutory requirements. This investigation can proceed at once while the General Assembly considers appropriate legislative action to bring about needed statutory changes.

In view of these recent developments and the continuing urgency of the health manpower crisis, we believe this is a timely document and one which can contribute to the removal of these restrictive barriers.

Myrna Bordelon Kassel

Myrna Bordelon Kassel, Ph.D.
Chairman, Interim Organization
for Chicago Area Allied Health Manpower

DATA FOR PLANNING

THE BARRIER

Planning for the allied health occupations is severely inhibited by the lack of information available for assessing current, intermediate and long range manpower needs within the State. Current labor market information, including occupational studies and forecasts, is incomplete and too general to assist the State, local governments and health-related agencies in developing sound plans.

THE RESULT

Since no effective overall planning is presently taking place, health service institutions, educators and manpower authorities are presently operating independently and without reference to any mutually understood set of goals or priorities for the State.

WE NEED

A centralized health manpower data bank for planning purposes. Such a data bank will involve comprehensive studies of present and projected needs for health manpower within the State. It will be necessary to obtain information on current and projected numbers and kinds of personnel employed in all health settings, including the new emerging community health care facilities.

MACHINERY FOR HEALTH MANPOWER PLANNING

THE BARRIER

While the State and the Chicago Metropolitan Area have established machinery for comprehensive health planning, models for effective health manpower planning within the framework of overall health care planning are still undeveloped.

THE RESULT

The lack of machinery for State and local health manpower planning contributes to ineffective recruitment, inadequate training capability, job development and placement services. At the local level the necessary linkages between the community organizations who can help in recruitment, the schools who can provide the training and the service institutions who provide the jobs are not developed. These factors discourage potential workers from entering the health field, leave many students to drop out of training and cause others who have completed training to withdraw from the health labor market.

WE NEED

Sound models for effective health manpower planning at the State and local levels to guide health planning authorities in evaluating their needs and marshalling their resources to meet them. Such models should provide operational links between community, professional and labor organizations, schools, hospitals, manpower programs, employers and others. In large metropolitan areas this machinery needs to be established on a sub-regional basis in order that it may remain closely related to local education resources and potential trainees and employers.

A MANPOWER PLAN TO ACCOMPANY ALL PROGRAM PROPOSALS

THE BARRIER

State and local authorities who are responsible for approving program proposals and/or granting funds to support health care programs do not always insist on the inclusion of a realistic and well designed manpower and staffing plan.

THE RESULT

Many programs which are approved and funded fall short of their objectives as the result of an inadequate or inappropriate manpower development and utilization plan.

WE NEED

To require that a set of manpower and staffing plans be included as an integral part of any proposal submitted by a health facility in which approval of local planning bodies and/or State funding are required.

TRAINING AVAILABILITY

THE BARRIER

Persons seeking training in the health occupations have no central resource available to them for obtaining information on existing training programs. The lack of such comprehensive information is a handicap to school counselors, employment counselors, educators planning new training programs and employers seeking continuing education opportunities for their employees.

THE RESULT

Some training resources are under-utilized because they are relatively unknown. Others are not developed to their full capabilities because the demand has never been fully expressed by applicants.

WE NEED

To establish and maintain a complete inventory of health occupations training opportunities throughout the State and a centralized information clearinghouse on available student slots.

To develop an information distribution network which will channel this information to all potential users of training resources.

LOCATION OF TRAINING AND TESTING SITES

THE BARRIER

Decisions made concerning the location of training programs do not appear to be based on considerations of need for specific kinds of trained manpower or the accessibility of the training program to the trainee population. Despite the acute need for dental technologists, for example, we have only three programs in the entire State, two in Chicago and one in Carbondale. Examinations for licensure for several health occupations are also inconveniently located.

THE RESULT

Costly and time-consuming transportation discourages persons from enrolling in training programs, particularly those who must continue working and cannot afford the loss of time away from their jobs. Similarly, the trip into Chicago which every person taking the Licensed Practical Nurse exam must make is an unnecessary burden on downstate persons, especially those with low incomes, work or household responsibilities.

WE NEED

To locate training programs in areas where 1) the highest priority of need for trained personnel exists; 2) facilities are easily accessible by available mass transit; and 3) a pool of potential manpower supply presently exists, can be developed or deployed.

To offer examinations in many locations throughout the State on the basis of their convenience and accessibility to the persons attempting to take these examinations.

POTENTIAL TRAINEE

THE BARRIER

We lack information about the potential manpower pools; that is, which kinds of youths and adults are motivated to enter the health occupations and why. We are equally uninformed about the effectiveness of various recruitment strategies and their effect on student retention.

THE RESULT

Recruitment efforts in the health occupations are not effective in obtaining the numbers and kinds of students needed.

WE NEED

A comprehensive study of student interest in the health occupations; an examination of current recruitment mechanisms and strategies as they relate to student retention and an evaluation of the cost effectiveness of these methods.

PEOPLE EXCLUDED

THE BARRIER

Partial or absolute blocks restrict the entry into certain health occupations of 1) disadvantaged persons and minority group members who cannot afford to pay for training or whose sub-standard basic education presently disqualifies them; 2) health workers who are performing competently on the job but do not have the prescribed academic degrees; and 3) women, older persons seeking second careers, ex-prisoners, ex-patients and others whose potential contribution is overlooked or underdeveloped.

THE RESULT

We pay the price for these discriminatory practices in an enormous waste of human resources. We also intensify the maldistribution of health manpower in inner city and under-serviced areas by neglecting to recruit from the economically and socially deprived populations.

WE NEED

To express and implement our full commitment at State and local levels as well as in the educational and health care systems to open opportunities for these groups by designing and mounting programs of intensive recruitment to bring these individuals into the health occupations.

To provide funds which will support the in-training, upgrading and maintenance of these workers in training through scholarships, loans, living allowances and work-study arrangements.

To make supportive services available including counseling, tutoring, day care and health services to help trainees remain in and complete their training programs.

TRAINING DESIGN

THE BARRIER

The design of training in the health occupations continues to place an undue emphasis on traditional liberal arts contents, primarily to insure the transferability of the student's credits to institutions of higher learning. For the majority of students, however, completion of high school or associate of arts degrees constitutes terminal education. In view of this fact, the issue of transferability of credit to senior institutions should not be the major focus of curriculum design.

THE RESULT

The student who does not wish or cannot afford to continue with bachelor's level or graduate work loses valuable training time that could be used more appropriately in preparing him for the world of work and the earning of a livelihood.

WE NEED

The schools, in collaboration with their advisory boards and the accrediting authorities, to redevelop and revise undergraduate education in the allied health occupations to provide a more judicious mix of general and technical education, one which conforms more closely to the actual labor market demands which will be made upon the individual after his graduation.

OVER-TRAINING AND UNDER-UTILIZATION

THE BARRIER

Training programs are designed by educational institutions to meet the standards set by professional groups and accrediting associations whose general tendency has been to raise requirements for entry and upgrading in the health occupations.

THE RESULT

Workers are over-trained for the actual jobs to be performed, resulting both in a wastage of scarce skills and training resources as well as the failure to fully utilize new workers who can perform lesser skilled jobs competently.

WE NEED

To perform a functional analysis of the work skills actually required at each level and to gear the content and duration of training programs to actual job requirements.

OBSOLETE TRAINING TECHNIQUES

THE BARRIER

We continue to use archaic training techniques in preparing workers for the allied health occupations. Programs are often unnecessarily lengthy, expensive to administer and overly-wedded to use of lecture methods and mere acquisition of information. We continue to adhere to fixed semester periods irrespective of the ability of many students to learn more rapidly or the needs of employers to enroll workers at times more convenient to the needs of the health service institution.

THE RESULT

We are wasting teaching and fiscal resources as well as the time of instructors and students, thus reducing the potential output of existing training programs. Furthermore, while didactic teaching methods may produce graduates who have extensive factual information, it is equally important that workers acquire a repertoire of flexible skills and positive attitudes towards service to people.

WE NEED

To introduce modern technological tools, such as closed circuit television, programmed instruction and other audio-visual equipment for classroom work, tutorial programs and individual home study.

To give greater emphasis to skill practice and development within the context of client and community needs.

To gear the length of a training program to the capability of the individual trainee to acquire the necessary knowledge and skills.

To set up programs at times that are responsive to the needs of the health care institutions who are collaborating with the college in a specific training program.

COMPETENCE TESTING

THE BARRIER

Under present Illinois statutes and educational practice, it is not possible for competent workers in certain allied health occupations to enter into training programs or to qualify for licensure or certification without having completed a prescribed academic training program.

THE RESULT

Large numbers of workers who have acquired knowledge and skill in ways other than academic training are excluded from advancement and/or official status in their occupation. These practices prevent employers from fully utilizing and giving appropriate compensation to competent workers who are capable of performing more responsible tasks. Educators waste scarce training resources by compelling workers to learn all over again what they already know.

WE NEED

To develop a battery of proficiency examinations for statewide use such as those developed by the State of New York. These examinations should be 1) available in many geographical locations; 2) acceptable to all educational institutions; and 3) designed to test performance capabilities rather than mere technical knowledge.

TEACHER SHORTAGES

THE BARRIER

We do not have enough qualified teachers to meet the needs in the allied health occupations for training staff. Under existing statutes, as well as regulations promulgated by State, local and professional agencies, academic requirements for instructors are set so high that competent potential teachers cannot be utilized in training programs.

THE RESULT

The shortage of accredited teachers makes it impossible for us to significantly expand our present training capacity in the State. The skills of many potential instructors are wasted under present restrictive regulations.

WE NEED

To increase and accelerate the training of allied health instructors.

To reduce the academic requirements specified for allied health instructors.

To build preparation for teaching others into training programs at all levels so that knowledge and skills can be shared by competent workers with trainee groups.

CONTINUING EDUCATION

THE BARRIER

Persons presently licensed or certified are assumed to remain competent workers on the basis of having passed a once-in-a-lifetime examination. The health care industry and the health care professions have not invested adequate resources in staff development for existing personnel.

THE RESULT

In view of the knowledge explosion and the rapidly changing technology in medical care, the failure to provide all health care workers with opportunities for continuing education contributes to the obsolescence of staff skills and consequently a deterioration of health care services.

WE NEED

An immediate expansion of continuing education for existing health care practitioners through in-service training programs as well as linkage with outside educational institutions.

A commitment on the part of employers to provide release time and to support the cost of such continuing education and maintenance of student and employee.

The development and implementation of standards which will require the demonstration of the continuing competence of a health worker as a criterion for renewing his licensure or certification.

ATTITUDES OF ADMINISTRATORS

THE BARRIER

While health is one of the prime growth industries in this country and therefore one of the fields which should carry high priority within the educational system, educational administrators are generally unfamiliar with the existing and emerging allied health occupations. This lack of knowledge and awareness is combined with the general tendency of educators at all levels to downgrade vocational programs as second-class education for second-class students.

THE RESULT

If we were earnestly to attempt to recruit and train the numbers and kinds of allied health workers we need now, the lack of available training resources in most communities would constitute a critical bottleneck. Even today, with recruitment and available funds far below the level of need, a serious shortage of training programs exists.

WE NEED

To encourage, through the State Board of Vocational Education, the Higher Education Board and the various educational associations, educational administrators 1) to become familiar with the rapidly expanding allied health field; 2) to increase the number of vocational counselors within the secondary system, and 3) to give health education programs high priority as well as full and equal treatment as first-class careers for first-class students.

VOCATIONAL EDUCATION UNNECESSARILY DELAYED

THE BARRIER

Vocational and technical education in the health occupations starts too late. We do not expose the high school student to career opportunities in the health field early enough nor do we provide training which will give him upon graduation the opportunity to work in the health care field at an attractive entry level salary.

THE RESULT

A serious loss of manpower potential, a waste of education, human and fiscal resources and a high dropout rate because education is regarded as irrelevant by the student or because he cannot afford to continue going to school.

WE NEED

To expand vocational education programs in health at the high school level to equip students with marketable skills upon graduation.

To articulate high school programs with community college programs so that training received in the high school provides opportunity for advanced placement in a two-year program.

To enlarge the health occupations consultant staff of the State Board of Vocational Education and Rehabilitation so that more communities may receive help in planning and implementing secondary school programs in health education.

PERSONNEL STRUCTURES AND STANDARDS

THE BARRIER

The health service institutions, particularly the hospitals, have not exercised their responsibilities as employers to develop industry-wide job classifications, personnel policies and standards which can best achieve their service objectives.

THE RESULT

Serious inequities in wages, working conditions, employer expectations and training requirements persist among health manpower users in the same community. Since training programs provided in one institution may not be acceptable in another, workers are often required to re-enter entry level training programs when they move into the same job in a new institution. This results in a waste of valuable staff time and the acceleration of training costs for which the consumer must ultimately pay.

WE NEED

The health service institutions to begin applying the techniques of systems analysis and functional job analysis in an industry-wide effort in each labor market area. This will require each institution to make a careful analysis of its functions and the levels of skill and training required to perform these functions. The goal is to identify the commonalities which exist and to encourage local inter-institutional compacts with respect to job descriptions, training requirements and basic conditions of work.

VERTICAL MOBILITY

THE BARRIER

Health educators in Illinois have not developed the inter-institutional agreements which will enable persons who have successfully completed training for one rung of the education ladder to proceed from that rung directly up to the next level of training in that occupation. In most communities in Illinois, for example, a Licensed Practical Nurse entering into an associate degree nursing program in the community college does not receive any credit or reduction in the time requirement. The same lack of articulation between training programs inhibits Dental Hygienists from moving up to becoming Dentists, Physical Therapy Assistants from becoming Physical Therapists and Medical Laboratory Technicians from becoming Medical Technologists.

THE RESULT

Forcing persons to repeat the same training they have already assimilated reduces motivation for entering advanced training programs and represents an unsupportable waste of scarce manpower, training resources and funds.

WE NEED

The community colleges, the four-year colleges and the universities to proceed immediately to implement genuine education ladders which will enable workers who have completed one level of training to move directly into the next, receiving full credit for their prior education. Since most students will have already successfully mastered portions of the advanced training program, such agreements should result in a considerable shortening of the length of time required to complete the advanced training.

HOR'ZONTAL MOBILITY

THE BARRIER

Health educators and professional groups have failed to identify the basic background of knowledge and skill which is common to all health workers. Each specialty has developed its own set of requirements independently of the others. Health workers attempting to move from one specialty into another, therefore, find that they must start from the bottom again.

THE RESULT

Practices which tend to freeze a worker into a single specialty limit his career options and his ability to adapt to changes in medical technology which may make his specialized skills obsolete. The educational costs involved in providing unique training programs for each specialty are excessive.

WE NEED

The educational institutions in Illinois to agree upon and establish basic health core curricula for the training of health workers at each academic level irrespective of specialty. Training to provide highly specific knowledge and skills should be conducted primarily in clinical training settings and on the job training sites.

The professional groups to begin developing inter-disciplinary agreements which can then be implemented by the educational institutions to enable workers to move from one health occupation into another with maximum transferability of credits for prior academic work and experience.

HIGH TURNOVER AND ATTRITION RATES

THE BARRIER

The health industry and the quality of health care suffer from an excessive turnover of hospital workers and a high attrition rate of trained personnel in certain occupations. Among the contributing factors are low entry level wages, poor working conditions, lack of opportunity for upward mobility and the insufficient motivation of many newly trained persons to remain in the health occupations.

THE RESULT

The costs, both monetary and social, to keep recruiting and training a continuing in-flow of new workers cannot be justified. In the interim the potential of presently employed and dedicated workers is grossly neglected.

WE NEED

To examine present attrition and turnover rates in the health fields and develop programs which will improve the retention and the morale of workers through changes in the reward and opportunity system as well as the conditions of work.

To open and accelerate programs to train and upgrade persons already employed, persons who are more mature, geographically stable and already committed to employment in the health care field.

HEALTH TEAM

THE BARRIER

Although health practitioners are aware that the effective delivery of services to clients requires the interaction and collaboration of many disciplines and skilled workers in the "health care team," the health industry remains one of the most hierarchic in contemporary society. Each level of worker is preoccupied in defending his status vis-a-vis those below and each specialty organizes separately to enhance its own interests.

THE RESULT

This climate does not support a rational division of labor or effective interdisciplinary teamwork based on the needs of the client. It is highly questionable whether we are in fact making best use of the manpower now employed or the scarce skills of highly trained specialists in present patterns of manpower utilization.

WE NEED

To design and demonstrate new models of staff utilization based upon the needs of clients and full commitment to the health care team concept.

PROGRAM FUNDING

THE BARRIER

Health agencies and community organizations who are eager and committed to the development of innovative service and training programs lack information about available funding resources. They are severely hampered in their efforts to secure multiple funding support by the incredible complexities of the procedures which are most frequently involved.

THE RESULT

Too many casualties of excellent program proposals occur as a result of the battle fatigue induced by efforts to obtain funding information or to put a package together involving more than one funding source.

WE NEED

To develop and make available to agencies an inventory of major funding sources, their policies and procedures. Such an inventory should lead to specific recommendations for greater simplification and clarity in approaching the funding agencies best equipped to handle specific program proposals.

PROFESSIONAL VERSUS PUBLIC INTEREST

THE BARRIER

Many professional groups continue to exert strong pressures to raise the educational requirements for entry into and mobility within the health occupations. Their primary concern seems to focus on "quality of care" as perceived and rendered by the particular professional group rather than by the relevancy of what is received by the community.

THE RESULT

Since the quality of service received by the community is not guaranteed by the standards set for itself by a particular professional group, professional control of the education and utilization of health manpower has restricted 1) the delegation of tasks which can be competently performed by lesser trained individuals; and 2) the optimum use of the human, fiscal and training resources available to achieve higher levels of health care for all persons in the community.

WE NEED

To document the activities of professional organizations and to suggest appropriate changes in procedures and policies that affect the production and utilization of health manpower.

To implement changes which will provide legitimate representation and utilization of professional groups, while at the same time protecting the community from the control of public policy by specialized interest groups.

LIMITATIONS ON THE NUMBER AND KINDS OF TRAINING PROGRAMS

THE BARRIER

There is a common perception that the Department of Registration and Education restricts the number and kinds of training programs which can be offered in a specific location. It appears to individuals and agencies that many of these decisions are made arbitrarily, without reference to local needs or capabilities and sometimes in opposition to the expressed wishes and priorities of local communities.

THE RESULT

It has been extremely difficult to obtain clarification as to the precise scope of the authority of the Department of Registration and Education in these matters, particularly in view of the conflicting interpretations which emanate from various representatives of the Department with respect to which actions require its official sanction. The effect has been to make trainers extremely apprehensive about effecting even the most minor changes in programs already approved, such as expanding or modifying programs to meet the needs of specific trainee groups and employers. This results in a failure to make full use of the training capabilities which are presently available in many communities throughout the State.

WE NEED

To proceed at once to obtain a clear statement from the Board of Registration and Education indicating who has final authority to determine the size and kind of training programs to be offered in a specific community. Such a statement should be widely distributed so that every training institution can proceed to exercise its legitimate decision-making authority within the framework of State law. As a general rule, programs should be authorized wherever local education authorities in consultation with employers and other community groups demonstrate their commitment, their training capability and the availability of jobs for graduates.

STATE LICENSURE AND CERTIFICATION

THE BARRIER

Licensure and certification procedures have been allowed to circumscribe the route a worker must take into the health occupations if he is to achieve any status in the system. Since the administration of these licensure and certification procedures is dominated by professional groups with specialized interests, the health occupations have become fragmented and over-specialized. Consumer participation is conspicuously absent in the shaping of public policy.

THE RESULT

Competent workers are prevented from moving vertically or horizontally in the health occupations because they lack the specific credentials specified by the Department of Registration and Education. Employers are inhibited from flexible use of the work force. While mandatory licensing measures are theoretically designed to protect the public, there is little evidence to show that they have actually contributed substantially to the quality of care and the public safety. Because present licensure proceedings contribute to the fragmentation of the health occupations, they have discouraged experimentation with new and more generic types of health workers.

WE NEED

A comprehensive inquiry into our present licensure and certification system to be followed by implementation of needed changes. In such an inquiry high priority should be given to 1) the restructuring of the State Department of Registration and Education to secure broad consumer participation in the development of public policy relating to the licensure and certification of the health occupations; and 2) an intensive investigation of the relevance of mandatory licensure and certification to health manpower production and the quality of health care.

II. BARRIER REMOVAL: A STATEMENT OF PROGRESS

What progress has been made in Illinois in removing the twenty-five barriers that restrict the effective recruitment, training and utilization of allied manpower?

The following summary is a response to this question. Its purpose is to cite, illustratively not exclusively, specific examples of progress Illinois is making in relation to each barrier.

The examples of progress cited reflect some change in attitude, intent and commitment to more effective allied health manpower planning, training, and utilization. The majority of these efforts, however, represent potentialities rather than actualities. The hope of actualizing these potentialities lies in the careful examination of each of these barriers and in the prompt and appropriate action to remove them.

A. DATA AND MACHINERY FOR PLANNING

(1 and 3)* Data and Machinery for Planning

In its January 1971 progress report, the Illinois Hospital Association listed the existence of forty (40) local comprehensive health planning organizations, associations, or agencies. The potential machinery for health planning is beginning to emerge.

On the state level, the Comprehensive State Health Planning Agency (CHPA) is federally mandated to function as the permanent machinery for such comprehensive health manpower planning. It is presently working in close conjunction with the Illinois Department of Public Health in developing a Total Health Information System (THIS) whose unique feature will be area profiles. The profiles will include essential data for manpower planning and development. As of September, 1971 the Physician and Nurse Manpower Registrar will be implemented.

*Numbers cited here and on the following pages refer to the numbers assigned to specific Barriers in Part I.

The State Comprehensive Health Planning Agency was also one of the originators of the Illinois Inter-Agency Task Force on Health Manpower and Education. The four other originating agencies include the Chicago Comprehensive Health Planning Organization, the Health Education Commission, the Illinois Regional Medical Program and the Health Careers Council of Illinois. These five agencies and the other agencies represented among task force members constitute a potentially innovative framework for manpower planning in Illinois. One of the Task Force's major objectives is to initiate and/or assist efforts to coordinate the collection and maintenance of data relevant to health manpower and education needs, production and utilization.

Also on the state level, the Health Education Commission (HEC) of the Illinois Board of Higher Education, in conjunction with the Rand Corporation and with the cooperation and prior efforts of professional and allied health associations has made progress in surveying present and projected manpower needs within discrete health fields. It is also developing a model for future health manpower need and utilization in Illinois (refer also to Training Availability 5).

On the local levels, federally empowered Comprehensive Health Planning Agencies (CHP Agencies) are the machinery for manpower planning. In the Chicago area, for example, the Metropolitan Comprehensive Health Planning Agency and its subarea planning bodies are involved in the Interim Organization for Chicago Area Allied Health Manpower. This organization is a successful effort to form a viable transitional machinery for health manpower planning until the permanent machinery is established.

CHP (b) in conjunction with Argonne Laboratories and the CONSAD Corporation is applying for federal and foundation monies to establish a comprehensive health data system for the Metropolitan Chicago area. If granted, this data

system could provide the operational base for coordinating, generating, and processing health manpower data.

Mid-Southside Health Planning Organization, a sub-area planning of CHP (b), in October 1970 completed a two year manpower survey of its planning area: Community areas 33-42. The survey included an inventory of health facilities, budgeted positions and vacancies, the potential community manpower pool, and the present and projected community based training programs. A Federal Grant is now pending to establish a sole purpose, not-for-profit corporation to operate a comprehensive Mid-South Allied Health Manpower Program. The corporation is designed to link the community organizations who will be responsible for recruitment with the local hospitals and schools who can provide the training. Finally it will link students who have successfully completed the training programs to the local health facilities who have committed jobs. Its on-going data base, employment registry and job bank information could be fed into a metropolitan manpower data system such as has been described.

The Mid-South model, if replicated in the three other sub-area planning units of CHP (b), might provide the beginnings of a permanent structure for health manpower planning in the Metropolitan Chicago area.

(2) Today's Vacancies

The Cooperative Area Manpower Planning System (CAMPS) was discussed as a potential permanent structure for a comprehensive job vacancy information system. The Chicago area CAMPS organization is composed of some 25 government agency representatives from state, county, and municipal governments. The agencies represented are mainly those whose interests in manpower development are strong. CAMPS has health manpower as a high priority. It is involved in an effort to integrate health care system planning with comprehensive manpower planning. At present, CAMPS is in a process of

reorganization. The future capability will depend to a large extent on federal manpower legislation now under consideration.

In February 1971, the Human Services Manpower Career Center conducted a feasibility study into the formation of such a job vacancy data gathering system. The initial focus of the system would be human service jobs including health within the public sector. The Interim Organization is presently working on plans to establish such a reporting system for job vacancies in health for the Chicago area. A sample questionnaire has already been constructed to determine budgeted vacancies and training programs in health care facilities, including nursing homes, group practices, solo practioners, public health agencies, laboratories, clinics and hospitals.

(4) Manpower Plan to Accompany All Program Proposals

Pending Illinois Health Facilities and Services Planning Act (HB2653) makes it mandatory for any new health facility proposal to include a manpower staffing plan.

B. TRAINING

Upon the recommendations of the Master Plan for Higher Education for a state survey of health manpower education, the Board of Education published in 1968 Education in the Health Fields for the State of Illinois, more commonly referred to as the Campbell Report. As a result, the Health Education Commission (HEC) was formed to "mobilize and coordinate" educational resources in order to increase the production of health care manpower. The Rand Corporation was consequently contracted to assist HEC in developing analytical tools to better insure effective health education planning.

Rand is currently doing research in health manpower requirements, education, and information system design. The emphasis is on the analysis of health manpower supply.

(5) Training Availability

In April, 1971, Rand issued a working draft of a Health Education File for the state. The file contains approximately 2000 cards, each representing one program per school. About 1400 distinct programs are classified, covering a variety of educational levels, the majority baccalaureate and occupation-oriented.

The Health Careers Council of Illinois (HCCI) maintains a comprehensive current inventory on all present and proposed training programs in the health fields. Its records formed the substance of the State Health Education File. The American Medical Association also publishes a Directory of Accredited Allied Medical Education Programs in the United States.

Although significant progress has been made in maintaining a central information system of existing training programs, more thought has to be given to putting this information in more usable form and making it more known to all interested parties. Little progress has been made in centralizing an information clearinghouse on available student slots. The Health Careers Council of Illinois, however, has announced in its April 1971 newsletter that it will conduct a study to develop a coordinated system of student recruitment and referral in the Metropolitan Chicago area among its allied health institutions.

(6) Location of Training and Testing Sites

Present and projected allied health programs that are in the community college system offer an added degree of accessibility to the trainee population. This accessibility has been coupled with some efforts to recruit from minority

groups who have previously been severely restricted from entry into certain health fields.

However, little or no progress has been achieved in improving the accessibility of testing sites. The Illinois Nurses Association is trying to increase the frequency of the Licensed Practical Nurse examinations as a first step toward expanding the number and location of testing sites. This present effort is particularly timely because the National Testing Board is unfortunately contemplating a reduction in the number of tests given annually from four to two.

(7) Potential Trainee

(8) People Excluded

The Board of Education, the Division of Health Occupation Careers, is active in recruiting among the minority groups. It also provides pre-vocational training as an integral component of the overall program.

(9) Training Design

(10) Over Training and Under-Utilization

(11) Obsolete Training Techniques

(12) Competence Testing

In the area of competency testing the progress is also slow and marginal. No statewide development of proficiency examinations in the health fields is in

sight. There are signs of progress. Seven out of ten collegiate nursing programs in Illinois provide challenging examinations which allow students to place out of certain courses. Policies, however, vary from school to school. Olive-Harvey campus of the Chicago City Colleges in collaboration with the University of Chicago Hospitals and Clinics will introduce proficiency examinations for a group of LPN's employed by the U. of C. This effort is an attempt to reduce the length of the standard two-year program. The directors of all the Chicago City College nursing programs have recently met to discuss this same type of examination.

(13) Teacher Shortages

Significantly, teacher shortage has been made the top priority issue by manpower experts in Illinois. This awareness is in itself a sign of progress. The Illinois Nurses Association is seeking additional state and federal funds for accelerated training in nursing to increase the number of nurses for teaching and leadership positions. This allocation would be used primarily to raise the diploma R.N. and the baccalaureate R.N. to the baccalaureate and M.A. levels respectively.

The University of Illinois Center for Medical Education and Training under a Kellog Grant is developing a teacher training program for practicing physical-therapists. The training program will increase the number of part-time teachers on the junior college level.

(14) Continuing Education

The continuing education of health care workers will contribute to increasing teacher supply, decreasing high turnover rates, and securing the continued high quality of health care. The wider adoption in Illinois of the American

Medical Association's policy on Peer Review and the membership of Illinois in the Midwest Continuing Professional Education for Nurses are examples of the growing commitment to continuing education in the health fields.

The Illinois Regional Medical Program (IRMP) has continuing education and training as its primary educational intent. Its purpose is to maintain and update knowledge and skill in order to improve the level of already qualified health professionals. It provides some funding to the Center for Educational Development's Division of Continuing Education at the University of Illinois Medical Center. The Division has been involved in consulting professional and allied health educators and organizations since 1969. As a necessary step toward making concrete the need for continuing education in health, they are in the process of developing and subscribing Illinois physicians to self-assessment procedures. At the Illinois State Medical Society's May 1971 meeting, they conducted a volunteer program of assimilated self-testing and evaluation for the attending physicians.

C. ADMINISTRATION- UTILIZATION

(15) Attitudes of Administrators

On the state level there is evidence of some improvement in attitudes toward allied health education. The establishment of HEC in 1969 and its work is one example. The State Board of Vocational Education and Rehabilitation has officially declared health occupations education to be the top priority item for 1971-1972. The State Board of Vocational Education has required, since 1969, evidence of a local plan for Vocational Information. It is encouraging that this requirement applies to the elementary as well as the secondary grades.

(16) Vocational Education Unnecessarily Delayed

(17) Personnel Structures and Standards

(18) Vertical Mobility

Since the health industry has failed to develop industry-wide job classifications and personnel policies and standards, horizontal mobility into a new health profession is severely impeded. More efforts are being exerted to develop mobility within a single discipline. The University of Chicago Hospitals and Clinics has a pending proposal for upgrading Nurse Aides to LPNs and LPNs to RNs as well as entry level to Basic Hospital Science to Certified Laboratory Assistant to Medical Laboratory Technician and entry level to clerical jobs. This might initiate a significant breakthrough for vertical career mobility in Illinois (refer to Competence Testing (12).

The Chicago Medical Schools Physical Therapy and Medical Technology Programs also intend to employ a closely inter-related training design that ensures the maximum credit in moving from the aide to assistant and assistant to therapist levels.

(19) Horizontal Mobility

The proposed Dermatological Assistant Program, a cooperative effort of the University of Chicago Hospitals and Clinics, and the Central YMCA College, might provide an opportunity for horizontal mobility. The trainee would first complete the Medical Laboratory Technician (MLT) program and then take more specialized courses that would qualify him as a dermatological assistant.

HB2157- This bill allows medical schools to admit with advanced standing students who have had accredited training in health related fields. Under this legislation, it will be possible for such students with prior training to complete their M.D. in less than 36 months.

(20) High Turnover and Attrition Rates

(21) Health Team

(22) Program Funding

The Health Careers Council of Illinois, and more recently the Interim Organization for Allied Health Manpower, sponsor seminars on funding sources and procedures. In view of the past and projected demand for their important service, a more sustained effort is needed to provide this type of assistance.

D. LICENSURE

(24) Limitations on the Number and Kinds of Training Programs

(23 & 25) Professional vs. Public Interest/State Licensure and Certification

The Illinois Inter-Agency Task Force on Health Manpower in concord with other health associations supported Governor Ogilvie's request for a moratorium on additional licensing and certification categories for health professions.

This declared moratorium is a concrete illustration of commitment to health manpower redefinition within Illinois. The Inter-agency Task Force has also accepted the invitation of the Governor's Office of Comprehensive State

Health Planning to collaborate in a short-term investigation of more creative and effective interpretations of the existing statutes affecting the recruitment, training, and utilization of health manpower.

The Illinois Hospital Association's May 1971 Document and Recommendations on Licensure in Illinois and House Bill 854 A (the Katz Bill) asking for a three-year commission to investigate licensure are also significant beginning stages of progress in overcoming barriers to a more rational health manpower development.

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SELECTED ILLINOIS GOVERNING STATUTES THAT NEED TO BE REEXAMINED

1. The Illinois Chiropody or Podiatry Law, Ill. Rev. Stat. 1969, Ch. 91, Sec. 73-89

2. The Illinois Dental Practice Act, Ill. Rev. Stat. 1967, Ch. 91, Sec. 56 a - 72h

3. The Illinois Medical Practice Act, Ill. Rev. Stat. 1967, Ch. 91, Sec. 1-39

4. The Illinois Nursing Act, Ill. Rev. Stat. 1967, Ch. 91 35.32 to 35.56

5. The Illinois Optometric Practice Act, Ill. Rev. Stat. 1969, Ch. 91 Sec. 105.1

6. The Illinois Pharmacy Practice Act, Ill. Rev. Stat. 1967, Ch. 91, Sec. 55.1 to 55.63

7. The Illinois Physical Therapy Registration Act, Ill. Rev. Stat. Ch. 91, Sec. 22.1 - 22.29

8. The Illinois Psychologist Registration Act, Ill. Rev. Stat. 1967 Ch. 91½, Sec. 401 - 427

9. The Illinois Veterinary Medicine and Surgery Practice Act, Ill. Rev. Stat. 1967, Ch. 16 3/4 Sec. 124.1 to 124.12

10. The U. S. Vocational Education Act, 1963, as amended 1968

SELECTED REFERENCES

American Hospital Association. Statement on licensure of health care personnel. Chicago, 1970.

American Medical Association, Council on Health Manpower. Resource paper. Chicago, 1970.

American Medical Association, Dept. of Health Manpower. Health manpower progress report. Chicago, 1969

American Medical Association, Dept. of Health Manpower. Licensure of health occupations. Chicago, 1970.

Blum, H. L. F. Wahl, G. M. Lemon, R. Jornlin and G. W. King. The multipurpose worker and the neighborhood multiservice center: initial experiences and implications of the Rodeo Community Service Center. American Journal of Public Health, Vol. 58, No. 3, March, 1968, p. 458-468.

Broadwell, Lucille. Overcoming barriers to health occupations education. Board of Education, Chicago, 1970.

Campbell, James A. A report on education in the health fields for State of Ill. Board of Higher Education, Vol. II. Chicago, 1968.

Grossmont College Conference on Bio-Medical Technology and Manpower. American Assoc. of Junior Colleges. Washington, D. C., 1970.

Health Administration Program. Barriers to manpower mobility and utilization. Univ. of Calif., Berkeley, 1971.

Hull, John T. An overview and analysis of factors contributing to present and future health manpower needs. Health Career Council of Ill., Chicago, 1966.

Ill. Comprehensive Health Planning Advisory Council, Health Manpower Committee. Resolutions concerning interagency health manpower committee. Chicago, 1970.

Ill. Interagency Task Force on Health Manpower. Tasks for the task force, Chicago, 1971.

Ill. Study Commission on Nursing Fact Book. Springfield, 1966.

Institute for Interdisciplinary Studies. The need for legislative change. Comprehensive Health Planning Agency of Minnesota, Minneapolis, 1970.

National Congress on Health Manpower. Summation of task group reports. American Medical Association, Chicago, 1970.

Report of the National Advisory Commission on Health Manpower. Appendix I, Vol. 1. U. S. Govt. Printing Office, Washington, D. C., Nov., 1967.

SELECTED REFERENCES (cont.)

Rosen, Sumner M. Change and resistance to change. Social Policy, Vol. 1, No. 5, Jan./Feb., 1971. p. 3-5, 15-25.

The Carnegie Commission on Higher Education. Higher education and the nation's health. Washington, D. C., Oct., 1970. p. 49-55.

U. S. Dept. of Health Education and Welfare. Public Health Services, Health Manpower Source Book, Section 2. Nursing personnel. U. S. Govt. Printing Office, Washington, D. C., 1953.

U. S. Dept. of Labor. Occupational licensing and the supply of nonprofessional manpower. Manpower Research Monograph No. 11, Washington, D. C., 1969.

Williams, Grier. Needed: a new strategy for health promotion. New England Journal of Medicine, Vol. 279, Nov., 7, 1968. p. 1031-1035.

APPENDIX III

HOSPITAL EMPLOYMENT SURVEY

For the following class of employees, please indicate the number of authorized (or budgeted) positions your hospital has at the present time in its table of organization, the numbers of such positions that are currently vacant, the annual (or monthly or bi-weekly) salary ranges from minimum to maximum for each position (if salary ranges are not used, please indicate present salaries from the lowest to the highest), and in brief, the qualifications of training and experience necessary for hiring. Two examples are given below:

Employment Classes	Number of Budgeted Positions	Number Positions Vacant	Salary Range Min.	Max.	General Qualifications
Physical Therapy Physical Therapist	5	1	7,920	11,800	B.S. & Ill. cert. as physical therapist
Physical Therapy Aide	9	3	4,700	6,360	H.S. diploma, no exp.

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BEGIN HERE:

Employment Classes*	Number of Budgeted Positions	Number Positions Vacant	Salary Range Min.	Max.	General Qualifications
Clinical Laboratory Services					

*Note: Do not include clerical, custodial or maintenance classes.

Employment Classes*	Number of Budgeted Positions	Number Positions Vacant	Salary Range Min.	Salary Range Max.	General Qualifications
Nursing and Related Services					
Occupational Therapy					
Orthotic and Prosthetic Technology					
Pharmacy					
Physical Therapy					

*Note: Do not include clerical, custodial or maintenance classes.

Employment Classes*	Number of Budgeted Positions	Number Positions Vacant	Salary Range Min.	Salary Range Max.	General Qualifications
Podiatry					
Radiologic Technology					
Psychology					
Social Services					
Other Rehabilitation Services					
Speech Pathology and Audiology					

*Note: Do not include clerical, custodial, or maintenance classes.

Employment Classes*	Number of Budgeted Positions	Number Positions Vacant	Salary Range Min.	Salary Range Max.	General Qualifications
Other Related Services					

*Note: Do not include clerical, custodial, or maintenance classes.

SUPPLEMENTARY SELECTED REFERENCES

A. Community Organization for Health Manpower

Blum, Hendrik, M. D. Barriers to manpower mobility and utilization. Berkeley, University of Calif. Health Administration Program, 1971.

Broadwell, Lucille. Overcoming barriers to health occupations education. Chicago, Chicago Board of Education, 1970.

Bunnell, K. P. Some aims for health careers councils. The Journal of School Health, Nov., 1966.

Campbell, James A., M. D., et al. Report on education in the health fields for State of Illinois Board of Higher Education. Chicago, 1968.

Duff, Raymond S. and August B. Hollingshead. Sickness and society. New York, Harper & Row, 1968.

Fitzpatrick, Robert, Ph.D. A survey of tasks and functions of social workers in the health field. Proceedings of the Second Conference for Social Workers in the Health Field, Pittsburgh, 1968.

Friedson, E., ed. The hospital in modern society. New York, Free Press, 1963.

Friedson, E. The profession of medicine: a study of the sociology of applied knowledge. New York, Dodd, Mead, 1970.

Ginzberg, Eli. Men, money and medicine. New York, Columbia University Press, 1969.

Ginzberg, Eli. Urban health services. New York, Columbia University Press, 1971.

Greenfield, Harry I. Allied health manpower: trends and prospects. New York, Columbia University Press, 1969.

Grossmont College Conference on Bio-Medical Technology and Manpower. Washington, American Association of Junior Colleges, 1970.

Hansen, W. Lee. The economics of health and medical care. Ann Arbor, University of Michigan, 1964.

Hartman, Gerhard and Garry A. Toerber. Health education, health manpower, and a system. Iowa City, University of Iowa, 1969.

Ginzberg, Eli and the Conservation of Human Resources Staff, Columbia University. Manpower strategy for the metropolis. New York, Columbia University Press, 1969.

Gordon, Robert A., ed. Toward a manpower policy. New York, John Wiley & Sons, 1967.

Himmelbauer, William. Occupational manpower requirements: projections for the State of Illinois in 1975. July 1968. (mimeo)

Lecht, Leonard A. Manpower needs for national goals in the 1970's. New York, Frederick A. Praeger, 1969.

Lester, Richard A. Manpower planning in a free society. Princeton, Princeton University Press, 1966.

Levitan, Sar A. and Garth L. Mangum. Making sense of federal manpower policy. Washington, joint publication of Institute of Labor and Industrial Relations, University of Michigan - Wayne State University and National Manpower Policy Task Force, 1967.

Levitan, Sar A. and Irving H. Siegel. Dimensions of manpower policy: programs and research. Baltimore, Johns Hopkins Press, 1966.

Mahoney, Thomas A. A stochastic model for manpower planning. Minneapolis, University of Minnesota, Industrial Relations Center, 1969.

Manpower administration, Canada manpower policy and programs. Manpower Research Bulletin No. 16. Washington, U. S. Dept. of Labor, Govt. Printing Office, Nov., 1968.

Manpower report of the President, March 1970. Washington, U. S. Govt. Printing Office, 1970.

Patterns of U. S. economic growth, Bulletin 1673. Washington, U. S. Dept. of Labor, Bureau of Labor Statistics, Govt. Printing Office, 1970.

Pisciotte, Joseph P., ed. Manpower for Illinois Governments. (Final Report and Background Papers, Assembly on Manpower for Illinois Governments.) Urbana, University of Illinois, 1968.

Ruttenberg, Stanley H. and Jocelyn Gutchess. The federal-state employment service: a critique. Baltimore, Johns Hopkins Press, 1970.

Ruttenberg, Stanley H. assisted by Jocelyn Gutchess. Manpower challenge of the 1970's: institutions and social change. Baltimore, Johns Hopkins Press, 1970.

Social welfare manpower needs in the Chicago area. Chicago, Welfare Council of Metropolitan Chicago, 1970.

Health manpower progress report. Chicago, American Medical Association, Dept. of Health Manpower, 1969.

Hedinger, Frederic Raymond. The systems approach to health services: a framework. Iowa City, University of Iowa, 1969.

Klarman, Herbert E. The economics of health. New York, Columbia University Press, 1969.

Lynton, E. F. New careers potentials in health: beyond the hospital, New York, New Careers Development Center, New York University, 1968.

Magraw, Richard M. Ferment in medicine. Ann Arbor, University of Michigan, 1964.

Occupational licensing and the supply of nonprofessional manpower. Washington, U. S. Dept. of Labor Research Monograph No. 11, 1969.

Resource papers. Chicago, American Medical Assoc. Council on Health Manpower, 1970.

Rosen, Sumner M., ed. Social policy, vol. 1, no. 5. White Plains, N. Y., International Arts and Sciences Press, Jan. - Feb., 1971.

Schulberg, Herbert C., et al., eds. Program evaluation in the health fields. New York, Behavioral Publications, 1969.

Teague, Dutton and Dorothy F. Buck, eds. Utilization of manpower in mental health and related areas. Boulder, Colo., Western Interstate Commission for Higher Education.

B. Manpower Planning

Bolino, August C. Manpower and the City. Cambridge, Mass., Schenkman Publishing Co., 1969.

David, Henry. Manpower policies for a democratic society. (Final statement of National Manpower Council). New York, Columbia University Press, 1965.

Delehanty, John A. ed. Manpower problems and policies. Scranton, Penn., International Textbook, 1969.

Douglas, Evalin F. Manpower and planning. New York, Industrial Relations Counselors, Inc., 1970.

Employment outlook for thirty-two selected occupations. Illinois Department of Labor, Bureau of Employment Security, 1970. (mimeo)

The measurement and interpretation of job vacancies: a conference report. New York, National Bureau of Economic Research, Columbia University Press, 1966.

The U. S. economy in 1980: a summary of BLS projections, bulletin 1673. Washington, U. S. Dept. of Labor, Bureau of Labor Statistics, Govt. Printing Office, 1970.

Theobald, Robert, ed. Social policies for America in the seventies: nine divergent views. Garden City, N. Y., Doubleday & Co., Anchor Books, 1963.

Toward a social report. Washington, U. S. Dept. of HEW, Govt. Printing Office, 1969.

U. S. Manpower in the 1970's: opportunity and challenge. Washington, U. S. Dept. of Labor, Govt. Printing Office, 1970.